BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual

Section F (g)

Filing Claims - Facility Services

Important Notes:

Throughout this provider manual there will be instances when there are references unique to Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "Plan" is referenced, the information will apply to all products.

Capitated Medical Groups - Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

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1 Filing Facility Claims Overview

It is important that providers submit facility claims accurately and completely. To assist, Blue Cross and Blue Shield of Texas has provided the following information and guidelines.

Note: *References to entering the "*Secure content" area of the General Reimbursement Information section of the provider website, requires you to obtain the password from your Network Management Office. This is area is only available to participating providers.*

2 Revenue and Procedure Codes - Facility Claims

When billing claims to BCBSTX, revenue codes, CPT® and HCPCS codes must be compatible. For example:

- Pathology services must be billed with the appropriate Pathology CPT code and the Revenue Code 031X. All Revenue codes should be extended to four digits.

If you have questions regarding proper matching of CPT codes to revenue codes, or the relevant billing units, information is provided through the National Uniform Billing Committee website at www.nubc.org and refer to your contract.

3 Clinical Payment and Coding Policies

Providers should refer to our Clinical Payment and Coding Policy page for current policies related to services they are providing. CPCPs are based on criteria developed using healthcare professionals and industry standard guidelines.

4 Room Rate Update Notifications

Numerous plan group and member benefits only provide for a semi-private room. The room rate on file and loaded in the claims payment system is used to determine the patient's liability for claims when the difference between the private room and the semi-private room is the patient's responsibility. Therefore, the accurate information that you provide, assists in adjudicating the claim with the correct patient liability.

A copy of the form is located on the provider website Forms page. For updates, please notify BCBSTX at least 30 days prior to the planned effective date.

5 Outpatient Admission Type Hierarchy

The admission type determines the applicable reimbursement. When the claim meets the definition of more than one admission type you would use the hierarchy matrix to determine which admission type will be used to determine the reimbursement. This matrix is located on the BCBSTX provider website under **Standards and Requirements** and then the *Secure content section of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr** then select **Reference Material.** The matrix is listed as **"Admission Type Hierarchy".**

6 Hospital Claims Filing Instructions

The Hospitals in the HMO networks have agreed to:

- Accept reimbursement for covered services on a negotiated price as stated in their contract.
- Provide utilization review and quality management programs to be consistent with those of their peers in the health care delivery system.
- Be responsible for notifying the Utilization Management Department of an elective admission prior to admission and an urgent/emergency admission within the later of 48 hours or by the end of the next business day.

6.1 Type of Bill

The correct type of bill must be used when filing claims. A claim with an inpatient TOB must have room and board charges. Refer to the NUBC UB-04 Manual for the valid codes.

6.2 National Provider Identifiers

Some facilities may have several NPI (e.g., substance abuse wings, partial psychiatric day treatment). It is important to bill the claim with the correct NPI for the service you provided, or this could delay payment or even result in a denial of a claim.

6.3 Patient Status

The appropriate patient status is required on an inpatient claim. An incorrect patient status could result in inaccurate payments or a denial.

6.4 Occurrence Code/Date

All accident, emergency and maternity claims require the appropriate occurrence code and the date. Refer to the NUBC UB-04 Manual for the valid codes.

6.5 Late Charges/Corrected Claims

Late and added charges should be submitted as a corrected claim after the original claim has been processed.

- For inpatient use: Type of Bill 117 for corrected claim
- For outpatient use: Type of Bill 137 for corrected claim

The corrected claim should include all line items previously processed correctly. Corrected claims can be filed electronically. If the corrected claim must be filed on paper, it should be submitted with a Corrected Claim Review Form.

7 Facility and Ancillary Reimbursement

The following define different types of facility reimbursements.

7.1 Diagnosis Related Group Facilities

DRG- means an all-inclusive method of compensation derived by assigning Facility patients into groupings by use of diagnosis, present on admission indicator, procedures, age, sex and discharge status.

Interim bills are not accepted for claims process for DRG reimbursement. Late charges/credits are not accepted on DRG Claims Unless they affect the reimbursement. Information used to determine a DRG:

- All the International Classification of Disease ICD-10 diagnoses billed on a claim
- All the ICD-10 Surgical Procedure Codes billed on a claim
- Patient's age
- Patient's sex
- Discharge status
- Present on Admission Indicator

Note: Outpatient Claims – When DRG Cap is contracted, in no instance will the Contract Rate for Outpatient Services be greater than the Inpatient Service Contract Rate would be if the Outpatient Services were done on an Inpatient basis, unless (1) the Outpatient Service method of compensation is a Case Rate, Per Diem, or (2) the Outpatient Services are for chemotherapy or radiation therapy.

Outpatient services for radiation therapy or chemotherapy as defined in the **Admission Type Definitions** posted on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/ Hospital/Ambul. Surg Ctr./Endoscopy Ctr**, select **Reference Material** then **Admission Type Definitions.**

In addition, refer to the **Admission Type Hierarchy** posted on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr,** select **Reference Material** then "**Admission Type Hierarchy**".

7.2 Fixed Fee Arrangements

Fixed-fee arrangements reflect a negotiated rate for services rendered. Different fixed-fee arrangements include inpatient hospital per diems, inpatient hospital case rates, outpatient case rates, and outpatient maximum allowable fee schedules. The Resource Based Relative Value Scale based fee schedule and DRG hospital rates are fixed-fee arrangements. Some facilities may be reimbursed billed charges up to the per diems as defined by the services rendered. Per diems are inclusive of all services and supplies based on the type of provider.

8 Preadmission Testing

Preadmission tests provided by the Hospital within three (3) days of admission should be combined and billed with the inpatient claim or any service (s) provided on the same day that resulted in an inpatient admission should be combined with the inpatient claim.

9 Pre-Op Tests

For outpatient day surgery, services should be billed as one claim to include the day surgery and the pre-op tests.

10 Mother & Baby Claims

Claims for the mother and baby should be filed separately.

11 Clinic Charges

BCBSTX does not reimburse facilities for Clinic Services, such as professional services by emergency room physicians or professional providers or physicians/ professional providers operating out of a clinic. These services are considered professional in nature and would be billed under the physician/professional provider's NPI #. Billing professional charges on a UB-04 will generate a denial message instructing the physician/professional provider to resubmit services on a CMS-1500 form.

Note: Professional charges will be allowed on a UB-04 when Medicare is primary for the member.

12 Diabetic Education

Diabetic education must be administered by or under the direct supervision of a physician. The Program should provide medical, nursing and nutritional assessments, individualized health care plans, goal setting and instructions in diabetes self-management skills.

Claims filing instructions: Must use diabetes as the primary ICD-10 diagnosis for the claim to be paid. The V code for the education/counseling would be listed as the secondary diagnosis.

13 Trauma

Trauma Definition – ICD – 10 codes must be in the Principal Diagnosis Field.

A list of the current **Trauma Admission Type ICD-10-CM Diagnosis Codes** for facility claims is located on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./ Endoscopy Ctr**, select **Reference Material** then "**Trauma Admission Type ICD-10- CM Diagnosis Codes**".

Please Note: Trauma claims will be paid as designated in your contract.

14 Provider Based Billing

Provider Based Billing means the method of split billing allowed by Medicare for clinic or physician practices owned, controlled or affiliated with the Hospital and the clinic/practice can be designated with Provider Based Status by The Centers for Medicare and Medicaid.

Refer to the **Admission Type Definitions** posted on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information page. After entering, go to **Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr**, select **Reference Material** then **Admission Type Definitions**.

Services rendered and/or provided in the Provider Based practices are not compensated by BCBSTX when billed by the Hospital as Outpatient Hospital services. All services including but not limited to surgery, lab, radiology, drugs, and supplies, rendered and/or provided in a Provider Based clinic or physician office are to be billed on a CMS-1500 form or in an equivalent electronic manner, using the "office" Place of Service and will be compensated according to the applicable professional fee schedule.

- The facility services not compensated will not be considered patient responsibility.
- Any services referred to or rendered by the hospital, such as lab and radiology, should be billed separately on a UB-04 by the Hospital.
- Excluded from this definition are Medicare Crossover claims, Medicare Advantage, Medicaid, and non-participating Indian Health Service providers.

Please note: This policy will be effective upon your contract renewal.

14.1 Provider Based Billing Claim Examples

Scenario 1 - Split Billing With In-Office Lab

Physician Claim:

Place of Treatment	Procedure	Compensation
22 – Outpatient Hospital	99212	Based on Facility RVU

Hospital Claim Example #1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0510	99212	

Hospital Claim Example #2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00

Correct Billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based on **Non-Facility** RVU
	A6250	
	80053	
	80061	
	J1205	

Scenario 2 - Split Billing Lab Referred to Hospital

Physician Claim

Place of Treatment	Procedure	Compensation
22 – Outpatient Hospital	99212	Based on Facility RVU

Hospital Claim Example #1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0510	99212	

Hospital Claim Example #2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0761	11042	
	0761	99212	

Correct Billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based on **Non-Facility** RVU
	11042	
	A6250	
	80053	
	80061	
	J1205	

Hospital Claim Example #2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0300	80053	Based on Contract Lab Schedule
	0300	80061	

Scenario 3 - Split Billing With In-Office Surgery and Lab Referred to Hospital

Physician Claim

Place of Treatment	Procedure	Compensation
22 – Outpatient Hospital	99212	Based on Facility RVU

Hospital Claim Example #1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0361	11042	
	0761	99212	

Hospital Claim Example # 2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00
	0270	A6250	
	0300	80053	
	0300	80061	
	0361	11042	
	0510	99212	

Correct Billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based on **Non-Facility** RVU
	11042	
	A6250	
	J1205	

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0300	80053	Based on Contract Lab Schedule
	0300	80061	

15 Diagnostic Services and Treatment Room Claims

Treatment Room Claim means the claim billed with National Uniform Billing Committee revenue codes 0760 or 0761 and with appropriate CPT/HCPCS codes representing the specific procedures performed or treatments rendered within the Treatment Room setting.

Treatment Room is used to bill for specific procedures performed or treatments rendered in the treatment room setting of the hospital. Use of the appropriate revenue code(s) describing Treatment Room along with the CPT/HCPCS code describing the procedure performed or treatment rendered is required. Refer to your contract language for additional information.

Refer to the **Admission Type Definitions** posted on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information page. After entering, go to

Reimbursement Schedules and Related Information/Hospital/Ambul. Surg Ctr./Endoscopy Ctr, select **Reference Material** then **Admission Type Definitions.**

Diagnostic Services and Treatment Room Claim Examples

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	According to contracted outpatient rates
	0270	A6250	
	0300	80053	
	0300	80061	
	0361	11042	

Correct Billing

Physician Claim

Place of Treatment	Procedure	Compensation
11 – Office	99212	Based **on Non-Facility** RVU
	11042	
	A6250	
	J1205	

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0300	80053	Based on Contract Lab Schedule
	0300	80061	

Treatment Room Claim Example

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	According to contracted outpatient rates for Treatment Room
	0270	A6250	
	0300	80053	
	0300	80061	
	0761	11042	

16 Non-Weighted DRGs

Refer to the **Admission Type Definitions** posted on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information page. After entering, go to **Hospital/Ambul. Surg Ctr./Endoscopy Ctr** then select **Reference Material** then **Admission Type Definitions**.

17 Filing UB-04 Claims for Ancillary and Facility Services

The following information provides filing guidelines for UB-04 claims for ancillary providers and facilities for:

- Ambulatory Surgery Centers/Outpatient Surgery Facilities
- Freestanding Cardiac Cath Lab Centers
- Dialysis

- Freestanding Emergency
- Home Health Care
- Non-Skilled Service
- Hospice
- Radiation Therapy
- Skilled Nursing
- Rehab Hospital

17.1 Ambulatory Surgery Center/Outpatient Hospital Surgery Claims Filing

- Must file claims electronically or submit the bill on a UB-04 claim form.
- Must file claims electronically or bill CPT or HCPCS code for each surgical procedure in form locator 44.
- Can bill with ICD-10 CM procedure codes and date procedure(s) was performed in form locator 74 and if applicable 74a-e.
- Use correct NPI in field 56.
- The Admission Type determines the applicable reimbursement. When the claim meets the definition of more than one Admission Type, the Admission Type Hierarchy matrix is used to determine which Admission Type will be used to determine reimbursement. Refer to the Admission Type Hierarchy posted on the BCBSTX provider website under the *Secure content area of the General Reimbursement Information. After entering, go to **Reimbursement Schedules** and **Related Information** then **Reference Material** located under the **Hospital/Ambul. Surg Ctr./Endoscopy Ctr.** topic.
- Incidental Procedures, as defined in the agreements for Ancillary providers, are not allowed in an ASC setting.
- Primary procedures will be reimbursed at 100% of the allowed amount; secondary and subsequent procedures will be reimbursed as stated in the provider's contract.
- Outpatient day surgery claims billed with the following revenue codes for prosthetics/orthotics and/or implants will be reimbursed based on the provider's contract:
    - 0274 – Prosthetic/Orthotic Devices
    - 0275 – Pacemaker
    - 0278 - Other Implants

17.2 Freestanding Cardiac Lab Centers

- Must file claims electronically or bill on a UB-04 claim form.
- Must itemize all services
- Number of units must be billed with each service to be paid appropriately.
- Must use the NPI in field 56.
- Cardiac Cath Lab procedures must be billed using the appropriate revenue code.
- Refer to your contract or contact your Network Management Office, if you need assistance.

17.3 Dialysis Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must bill ancillary services on the same claim with treatment.
- Must itemize all services.
- Must use appropriate revenue codes and CPT/HCPCS codes for services rendered (Refer to the UB-04 manual and your contract).
- Must file with your NPI number.
- Per diem rates include the following charges:

- Ancillary supplies
- Laboratory procedures
- Radiological procedures
- Additional diagnostic testing
- All nursing services
- Utilization of in facility equipment
- I.V. solutions
- All pharm

Note: The per diem is applicable only on day(s) that an actual treatment is provided.

17.4 Freestanding Emergency Centers Claim Filing

- Must file claims electronically or bill on a **UB-04** claim form.
- Must file with your NPI number.
- Must bill using revenue codes 0450, 0451, 0452 and 0459.
- Must bill with the applicable Evaluation and Management CPT code(s) and will be reimbursed based on the provider's contract.

17.5 Home Health Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must file with your NPI number.
- Must use appropriate revenue codes and HCPCS codes for services rendered
- *(see below and refer to the UB-04 Manual)*.
- Type of bill should be 321 or 327 for corrected claims.
- For additional information, refer to the section F(f) - **Ancillary Services** posted on the BCBSTX provider website under General Reimbursement Information.
- Services must be ordered by a physician and require a physician signed treatment plan or a Physician Assistant or Advance Practice Nurse (counter signature by their supervising physician).
- The needs of the patient can only be met by intermittent, skilled care by a licensed nurse, physical, speech or occupational therapist, or medical social workers.
- The needs of the patient are not experimental, investigational, or custodial in nature.

The following are examples of services which would be considered skilled:

- Initial phases of a regimen involving administration of medical gases.
- Intravenous or intramuscular injections and intravenous feeding except as indicated under non-skilled services.
- Insertion or replacement of catheters except as indicated under non- skilled services.
- Care of extensive decubitus ulcers or other widespread skin disorders.
- Nasopharyngeal and tracheostomy aspiration.
- Health treatments specifically ordered by a physician/ANP/PA as part of active treatment and which require observation by skilled nursing personnel to adequately evaluate the patient's progress
- Teaching – the skills of a licensed nurse may be required for a short period of time to teach family members or the patient to perform the more complex non-skilled services such as range of motion exercises, pulmonary treatments, tube feedings, self-administered injections, routine catheter care, etc.

17.6 Non-Skilled Service Examples for Home Health Care Claim Filing

The following are considered supportive or unskilled and will not be eligible for reimbursement when care consists solely of these services:

- General methods of treating incontinence, including the use of diapers and rubber sheets.

- Administration of routine oral medications, eye drops, ointments, and use of heat for palliative or comfort purposes.
- Injections that can be self-administered *(i.e., a well-regulated diabetic who receives daily insulin injections).*
- Routine services with indwelling bladder catheters, including emptying and cleaning containers, clamping tubing, and refilling irrigation containers with a solution.
- Administration of medical gases and respiratory therapy after the initial phases of teaching the patient to institute therapy.
- Prophylactic and palliative skin care, including bathing and application of creams or treatment of minor skin problems.
- Routine care with plaster casts, braces, colostomy, ileostomy, and similar devices.
- General maintenance care of colostomy, gastrostomy, ileostomy, etc.
- Changes of dressings in non-infected postoperative or chronic conditions.
- General supervision of exercises that have been taught to the patient or range of motion exercises designed for strengthening or to prevent contractures.
- Assistance in dressing, eating, and going to the toilet.
- Tube feeding on a continuing basis after care has been instituted and taught.

17.7 Hospice Claim Filing

- Must file claims electronically or bill on a **UB-04** claim form.
- Must use appropriate revenue codes and CPT/HCPCS codes for services rendered (Refer to the UB-04 Manual and your contract).
- When prior authorization is required or recommended clinical review is available based on the member's benefits, request prior authorization or RCR before services are rendered.
- Must itemize all services and bill standard retail rates.
- Inpatient services and home services cannot be billed together on the same claim.
- Must use NPI in field 56.
- Type of bill must be 811 if non-hospital based, or 821 if hospital based *(form locator 4).*
- Form locators 12 *(Source of Admission)* and 17 *(Patient Status)* are required fields. If either field is blank, the claim will be returned for this information *(refer to your UB-04 manual for the correct codes).*
- Form locator 63 must be completed with a referral number and a prior authorization number from the HMO.

17.8 Radiation Therapy Center Claim Filing

- Must file claims electronically or bill on a UB-04 claim form if the facility is Hospital Based or on a CMS-1500 if the facility is freestanding.
- Must bill negotiated rates according to fees stated in the contract.
- Must use the appropriate revenue codes and the corresponding CPT/HCPCS

17.9 Skilled Nursing Facility Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must use appropriate revenue codes (e.g., 190-194 and 199) for services rendered *(refer to UB-04 manual and your contract).*
- Must itemize all services and bill standard retail prices.
- Must use NPI in field 56.
- When prior authorization is required based on the member's benefits, request prior authorization before services are rendered.
- Must initiate prior authorization no later than the 21st day of confinement when Medicare A is primary for patients with HMO secondary coverage.

- Must use a type of bill 211 (form locator4)
- A room and board revenue code must be billed.
- Must use type of bill 131 and attach a copy of the Explanation of Medicare Benefits when filing services for a member who has Medicare Part B only.
- All non-routine items must be supplied by the appropriate provider specialty. For example, a special hospital bed or customized wheelchair provided to the patient must be supplied and billed by a DME provider.

17.10 Rehab Facility Claim Filing

- Must file claims electronically or bill on a UB-04 claim form.
- Must use appropriate room revenue code ending in eight (8). For example, private rehab room 0118 and semiprivate room 0128.
- When prior authorization is required or RCR is available based on the member's benefits, request prior authorization or RCR before services are rendered.

Consult the member benefit booklet or contact a customer service representative to determine coverage for a specific medical service or supply. Providers may also check Eligibility and benefits to determine if a prior authorization is required.