BlueCross BlueShield of Texas

Blue Choice PPO℠ and Blue High Performance Network® (BlueHPN)® Provider Manual - Filing Claims – Billing Requirements

Important note: Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

In this Section

The following topics are covered in this section:

Blue Choice PPO and BlueHPN Provider Manual -Filing Claims – Billing Requirements

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Billing Requirements Overview

This section provides an overview of Blue Cross and Blue Shield of Texas related to coordination of benefits and appropriate claims submission information.

Coordination of Benefits and Patient Share

Subscribers occasionally have two or more benefit policies. When they do, the insurance carriers take this into consideration and this is known as Coordination of Benefits. The following assists providers in understanding the coordination of benefits clause from the contracting perspective.

The information contained in this article applies to subscriber's health benefit policies issued by BCBSTX. Please note, some Administrative Services Only self-funded groups may elect not to follow the general COB rules of BCBSTX.

When the subscriber's health benefits policy is issued by another Blues plan, also known as the HOME plan, the COB provision is administered by that HOME plan, not BCBSTX. Therefore, the subscriber's HOME plan health benefits policy will control how COB is applied to that subscriber.

Per the BCBSTX COB contract language, the health care providers have agreed to accept the BCBSTX allowable amount (as defined by the contract) less any amount paid by the primary insurance carrier.

What does this mean for you?
Once the claim has been processed by BCBSTX as the secondary carrier, the only patient share amount that may be collected from the subscriber is the amount showing on the BCBSTX Provider Claim Summary.

The primary carrier does not consider the subscriber's secondary coverage. This means that once the claim is processed as secondary by BCBSTX, any patient share amount shown to be owed on the primary carrier's explanation of benefits is no longer collectible. If you have questions regarding a specific claim, please contact Provider Customer Service at **800-451-0287** to speak to a Customer Service Advocate.

Coordination of Benefits / Subrogation

BCBSTX attempts to coordinate benefits whenever possible, including follow-up on potential subrogation cases in order to help reduce overall medical costs.

Other coverage information may be obtained from a variety of sources, including the health care provider. Quite often a health care provider treating a subscriber is the first person to learn about the potential for other coverage. Information such as motor vehicle accidents, work-related injuries, slips/falls, etc. should be communicated to BCBSTX for further investigation.

In addition, each health care provider shall cooperate with BCBSTX for the proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, third-party liens, and other third-party liability.

BCBSTX contracted health care providers agree to file claims and encounter information with BCBSTX even if the physician or professional provider believes or knows there is a third-party liability.

To contact BCBSTX regarding:

- Coordination of benefits, call **888-588-4203**
- Subrogation cases, call **800-582-6418**

Coordination of Benefits Questionnaire

The COB questionnaire is mailed to our subscribers periodically based on information contained in our BCBSTX files, length of time since last updated and information submitted on claims and received through inquiry.

The COB questionnaire is also available on the BCBSTX Provider website under **Education and Reference** then Forms. The subscriber has the option of either calling Customer Service or responding to the questionnaire for BCBSTX to have the information needed to process claims.

Correct Coding

Use the appropriate Current Procedural Terminology (CPT®) and International Classification of Diseases codes on all claims

Splitting Charges on Claims

When billing for services provided, codes should be selected that best represent the services furnished. In general, all services provided on the same day should be billed under one electronic submission or when required to bill on paper, utilize one CMS- 1500 claim form when possible. When more than six services are provided, multiple CMS-1500 claim forms may be necessary.

Services Rendered Directly By Health Care Provider

If services are rendered directly by the **Plan** health care provider, the services must be billed by the **Plan** health care provider. However, if the **Plan** health care provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services.

All covered services provided for and billed for members by participating provider shall be performed personally by the participating provider and/or under their direct and personal supervision and in their presence, except as otherwise authorized and communicated by BCBSTX. Direct personal supervision requires that a participating provider be in the immediate vicinity to perform or to manage the procedure personally, if necessary.

Notes:

1) This does not apply to services provided by an employee of a **Plan** health care provider e.g. Physician Assistant, Licensed Surgical Assistant Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered Nurse First Assistant, who is under the direct supervision of the billing health care provider.
2) The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a PA, APN or RNFA:

AS Modifier: A physician should use this modifier when billing on behalf of a PA, APN or RNFA for services provided when these providers are acting as an assistant during surgery.
*(Modifier AS to be used **ONLY** if they assist at surgery).*

SA Modifier: A supervising physician should use this modifier when billing on behalf of a PA, APN, of RNFA for **non-surgical** services.

*(Modifier SA is used when the PA, APN, or RNFA is assisting with any other procedure that **DOES NOT** include surgery.)*

Billing for Non-Covered Services

If BCBSTX determines in advance that a proposed service is not a covered service, a health care provider must inform the subscriber in writing in advance of the service rendered. The subscriber must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the Subscriber.

To clarify what the above means - if you contact BCBSTX and find out that a proposed service is not a covered service - you have the responsibility to pass this along to your patient (our subscriber). This disclosure protects both you and the member. The subscriber is responsible for payment to you of the non- covered service if the member elects to receive the service and has acknowledged the disclosure in writing.

Please note that services denied by BCBSTX due to bundling or other claim edits may not be billed to the subscriber even if the subscriber has agreed in writing to be responsible for such services. Such services **are** Covered Services but are **not payable services** according to BCBSTX claim edits.

Surgical Procedures Performed in the Health Care Provider's Office

When performing surgical procedures in a non-facility setting, the health care provider reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a subscriber receives these services in the health care provider's office. Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the health care provider's office. To help determine how coding combinations on a claim may be evaluated during the claim adjudication process, you may utilize Clear Claim ConnectionTM (C3). C3 is a free online reference tool that mirrors the logic behind the auditing software BCBSTX uses. Refer to the BCBSTX provider website for additional information on access and using C3.

Please note the health care provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment vendor. Claims from the surgical equipment or DME vendor will be denied because the global reimbursement includes staff and equipment.

Contracted Health Care Providers Must File Claims

As a reminder, health care providers must file claims for any covered services rendered to a patient enrolled in a BCBSTX health plan. You may collect the full amounts of any deductible, coinsurance or copayment due and then file the claim with BCBSTX. Arrangements to offer cash discounts to an enrollee in lieu of filing claims with BCBSTX violate the requirements of your health care provider's contract with BCBSTX.

Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed Health Insurance Portability and Accountability Act (to add a requirement that if a patient self-pays for a service in full and directs a health care provider to not file a claim with the patient's insurer, the health care provider must comply with that directive and may not file the claim in question. In such an event, you must comply with HIPAA and not file the claim to BCBSTX.

CPT Modifier 50 Bilateral Procedures – Professional Claims Only

Modifier 50 is used to report bilateral procedures that are performed during the same operative session by the same physician in either separate operative areas (e.g. hands, feet, legs, arms, ears), or one (same) operative area (e.g. nose, eyes, breasts).

The current coding manual states that the intent of this modifier is to be appended to the appropriate unilateral procedure code as a one-line entry on the claim form indicating the procedure was performed bilaterally (two times).

An example of the appropriate use of Modifier 50:

Procedure Code	Billed Amount	Units/Days
64470-50	$#####.##	1

When using Modifier 50 to indicate a procedure was performed bilaterally, the modifiers LT (Left) and RT (Right) should not be billed on the same service line. Modifiers LT or RT should be used to identify which one of the paired organs were operated on. Billing procedures as two lines of service using the left (LT) and right (RT) modifiers are not the same as identifying the procedure with Modifier 50. Modifier 50 is the coding practice of choice when reporting bilateral procedures. When determining reimbursement, the BCBSTX Multiple Surgery Pricing Guidelines apply. These guidelines are located on our provider website under **Standards and Requirements**, General Reimbursement Information and then **Reimbursement Schedules and Related Information (Secure Content)**. You will need to obtain the password from your Network Management Office. This is area is only available to participating providers.

Proper Speech Therapy Billing

CPT codes 92507 and 92508 are defined as speech/hearing therapy codes. Codes 92507 and 92508 are not considered time-based codes and should be reported only one time per session; in other words, the codes are reported without regard to the length of time spent with the patient performing the service.

Because the code descriptor does not indicate time as a component for determining the use of the codes, you need not report increments of time (e.g., each 15 minutes). Only one unit should be reported for code 92507 and 92508 per date of service. BCBSTX adheres to CPT guidelines for the proper usage of these CPT codes.

Note: Unless there are extenuating circumstances documented in your office notes — for example, multiple visits on the same day — we will only allow one unit per date of service for these codes.

Care Coordination Services

BCBSTX recognizes the following Category I CPT codes for billing care coordination services: 99487, 99488 and 99489. BCBSTX reimbursement will be subject to the maximum benefit limit specified in the subscriber's benefit plan.

Blue Choice PPO and BlueHPN Provider Manual – Filing Claims – Billing Requirements

National Drug Code
Billing Guidelines for Professional Claims

BCBSTX requests the use of National Drug Codes and related information when drugs are billed on professional/ ancillary electronic (ANSI 837P) and paper (CMS-1500) claims.

Where do I find the NDC?

The NDC is found on the medication's packaging. An asterisk may appear as a placeholder for any leading zeros. The container label also displays information for the unit of measure for that drug. NDC units of measure and their descriptions are as follows:

- **UN** (Unit) – If a drug comes in a vial in powder form and has to be reconstituted
- **ML** (Milliliter) – If a drug comes in a vial in liquid form
- **GR** (Gram) – Generally used for ointments, creams, inhaler or bulk powder in a jar
- **F2** – International units, mainly used for anti-hemophilic factor (AHF)/Factor VIII (FVIII)

How do I submit the NDC on my claim?

Here are some quick tips and general guidelines to assist you with the proper submission of valid NDCs and related information on electronic and paper professional claims:

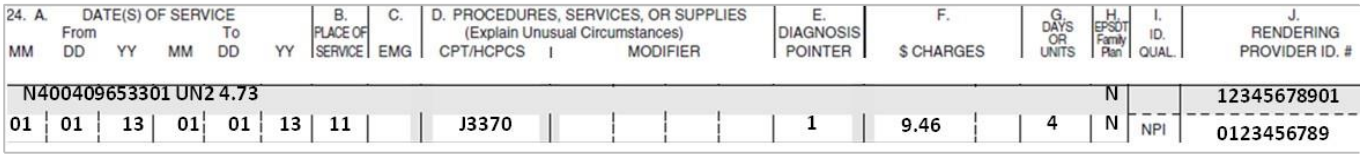
- The NDC should be submitted along with the applicable Healthcare Common Procedure Coding System or Current Procedural Terminology code(s) and the number of HCPCS/CPT units.
- The NDC must follow the 5digit4digit2digit format (11 numeric characters, with no spaces, hyphens or special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 5-4-2 configuration.
- The NDC must be active for the date of service
- The **NDC qualifier, number of units*, unit of measure** and **price per unit** should also be included

ELECTRONIC CLAIM GUIDELINES (ANSI 5010 837P)

Field Name	Field Description	Loop ID	Segment
Product ID Qualifier	Enter **N4** in this field.	2410	LIN02
National Drug Code	Enter the 11-digit NDC assigned to the drug administered.	2410	LIN03
Monetary Amount	Enter the monetary amount (charge per NDC unit of product)	2400	SV102
National Drug Unit Count	Enter the quantity (number of NDC units)	2410	CTP04
Unit or Basis for Measurement	Enter the NDC unit of measure ~~of~~ for the prescription drug given (**UN**, **ML**, **GR**, or **F2**)	2410	CTP05

PAPER CLAIM GUIDELINES (CMS-1500)

In the ***shaded portion*** of the line-item field 24A-24G on the CMS-1500, enter the qualifier **N4 (left-justified), immediately followed by** the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (**UN**, **ML**, **GR,** or **F2**), followed by the quantity (number of NDC units up to three decimal places), one space and the price per NDC unit, as indicated in the example below.



24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N400409653301 UN2 4.73													N		12345678901
01	01	13	01	01	13	11		J3370		1	9.46	4	N	NPI	0123456789

***Home Infusion and Specialty Pharmacy providers, please note:** BCBSTX **allows decimals** in the NDC Units (quantity or number of units) field. If you do not include appropriate decimals in the NDC Units field, you could be underpaid.

Note: Reimbursement for discarded drugs applies only to single-use vials. Multi-use vials are not subject to payment for discarded amounts of the drug.

Blue Choice PPO and BlueHPN Provider Manual -Filing Claims – Billing Requirements

Billing & Documentation Information & Requirements

Permissible Billing

BCBSTX does not permit **pass-through billing, splitting all-inclusive bills, under-arrangement billing**, and any billing practices where a provider or entity submits claims by or for another provider not otherwise provided for in the provider's agreement or in this policy.

Pass-Through Billing

Pass-through billing occurs when the ordering health care provider requests and bills for a service, but the service is not performed by the ordering health care provider.

The performing health care provider is required to bill for the services they render unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing:

- The service of the performing health care provider is performed at the place of service of the ordering physician or professional provider and billed by the ordering physician or professional provider;
- The service is provided by an employee of a health care provider (i.e., physician assistant, surgical assistant, advanced nurse practitioner, clinical nurse specialist, certified nurse midwife or registered first assistant who is under the direct supervision of the ordering physician or professional provider); and the service is billed by the ordering physician or professional provider.
- The service is billed by the ordering physician or professional provider.

The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a PA, APN or RNFA:

- **AS** modifier: A physician should use the AS modifier when billing on behalf of a PA, APN or RNFA, including that providers National Provider Identifier, for services provided when the PA, APN, or RNFA is acting as an assistant during surgery. Modifier AS is to be used ONLY if the PA, APN, or RNFA assists at surgery.
- **SA** modifier: A supervising physician should use the SA modifier when billing on behalf of a PA, APN, or RNFA for non-surgical services. Modifier SA is to be used when the PA, APN, or RNFA is assisting with any other procedure that DOES NOT include surgery.

Under-Arrangement Billing

"**Under-arrangement**" billing and other similar billing or service arrangements are not permitted by BCBSTX. "Under-arrangement" billing refers to situations where services are performed by one health care provider but the services are billed under the contract of another health care provider, rather than under the contract of the health care provider that performed the services.

Billing & Documentation Information & Requirements, cont'd

All-Inclusive Billing

Any testing performed on patients treated by a health care provider that is compensated on an all-inclusive rate should not be billed separately by the facility or any other provider. The testing is a part of the per diem or outpatient rates paid to a facility for such services. The health care provider may, at their discretion, use other providers to provide services included in their all-inclusive rate, but remain responsible for costs and liabilities of those services, which shall be paid by the facility and not billed directly to BCBSTX.

For all-inclusive billing, all testing and services that share the same date of service for a patient must be billed on one claim. Split billing is a violation of network participating provider agreements.

Other Requirements and Monitoring

CLIA Certification Requirement

Facilities and providers who perform laboratory testing on human specimens for health assessment or the diagnosis, prevention, or treatment of disease are regulated under the Clinical Laboratory Improvement Amendments of 1988. Therefore, any provider who performs laboratory testing, including urine drug tests, must possess a valid a CLIA certificate for the type of testing performed.

Review of Codes

BCBSTX may monitor the way test codes are billed, including frequency of testing. Abusive billing, insufficient or lack of documentation to support the billing, including a lack of appropriate orders, may result in action taken against the provider's network participation and/or 100% review of medical records for such claims submitted.

Limitations and Conditions

Reimbursement is subject to:

- Medical record documentation, including appropriately documented orders
- Correct CPT/HCPCS coding
- Member Benefit and Eligibility
- Applicable BCBS Medical Policy(-ies)

Obligation to Notify BCBSTX of Certain Changes

Health care providers are required to notify BCBSTX of material changes that impact their contract with BCBSTX including the following:

- Change in ownership
- Acquisitions
- Change of billing address
- Change in the billing information
- Divestitures

Blue Choice PPO and BlueHPN Provider Manual -Filing Claims – Billing Requirements

Other Requirements and Monitoring

Assignment

As a reminder, no part of the contract with BCBSTX may be assigned or delegated by a health care provider without the express written consent of both BCBSTX and the contracted provider.

Providers who choose to utilize a third-party billing service remain solely responsible for compliance with the requirements of all applicable provider billing practices under the terms of this contract. It is the responsibility of the provider to ensure claims submitted on their behalf are accurately and appropriately filed.

Fraudulent Billing

BCBSTX considers abusive or fraudulent billing to include, but not be limited to, the following:

1. misrepresentation of the services provided to receive payment for a non-covered service;
2. billing in a manner which results in compensation greater than what would have been received if the claim were properly filed; and/or
3. billing for services which were not rendered.

If BCBSTX determines, in its sole discretion, that a provider has engaged in abusive or fraudulent billing practices, BCBSTX may take further actions up to and including termination of the provider from any network.

Other Requirements and Monitoring

Providers with Multiple Specialties

If you have obtained a unique Organization (Type 2) National Provider Identifier number for each specialty, you should bill with the appropriate Individual (Type 1) and Organization (Type 2) NPI number combination accordingly.

In the absence of a unique Organization (Type 2) NPI number for each specialty, you are strongly encouraged to include the applicable taxonomy code* in your claims submission. Taxonomy codes play a critical role in the claims payment process for providers practicing in more than one specialty. Electronic claims transactions accommodate the entry of taxonomy codes and will assist BCBSTX in selecting the appropriate provider record during the claims adjudication process. For assistance in billing the taxonomy code in claim transactions, refer to your practice management software and/or clearinghouse guides.

* *The health care provider taxonomy code set is a comprehensive listing of unique 10-character alphanumeric codes. The code set is structured into three levels—provider type, classification, andarea of specialization—to enable individual, group, or institutional providers to clearly identify their specialty category or categories in HIPAA transactions. The entire code set can be found on the Washington Publishing Company website. The health care provider taxonomy code set levels are organized to allow for drilling down to a provider's most specific level of specialization.*