BlueCross BlueShield of Texas

Blue Essentials℠ (formerly known as HMO Blue Texas℠), Blue Advantage HMO℠ and Blue Premier℠ Provider Manual - Filing Claims

THIS SECTION CONTAINS A REQUIRED DISCLOSURE CONCERNING CLAIMS PROCESSING PROCEDURES

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name

In this Section

The following topics are covered in this section:

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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In this Section, Cont'd

The following topics are covered in this section:

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Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Note	**For information about behavioral health claims filing, refer to the "Behavioral Health" Section in the Provider Manual**
Blue Essentials Only Important Note	**Blue Essentials** physicians, professional providers, facility and ancillary providers who are contracted/affiliated with a capitated IPA/ Medical Group must contact the IPA/Medical Group for instructions regarding referral and preauthorization processes, contracting, and claims-related questions. Additionally, **Blue Essentials** physicians, professional providers, facility and ancillary providers who are not part of a capitated IPA/Medical Group but who provide services to an **Blue Essentials** member whose PCP is contracted/affiliated with a capitated IPA/Medical Group must also contact the applicable **Blue Essentials** physicians, professional providers, facility and ancillary providers who are contracted/affiliated with a capitated IPA/Medical Group are subject to that entity's procedures and requirements for **Blue Essentials** physicians, professional providers, facility and ancillary providers complaint resolution.

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Claims Processing Questions

Should you have a question about claims processing, as the first point of contact, call your electronic connectivity vendor, i.e., Availity or other electronic connectivity vendor of your choice or contact **Blue Essentials, Blue Advantage HMO or Blue Premier** Provider Customer Service:

Blue Essentials – 877-299-2377
Blue Advantage HMO – 800-451-0287
Blue Premier – 800-876-2583

Claims Submission-Timely Claims Filing Procedures

Blue Essentials, Blue Advantage HMO and Blue Premier claims must be submitted within 180 days of the date of service. **Blue Essentials, Blue Advantage HMO and Blue Premier** physicians, professional providers, facility and ancillary providers must submit a complete claim for any services provided to a member. Claims that are not submitted within **180** days from the date of service are not eligible for reimbursement. Claims submitted after the designated cut-off date will be denied on a Provider Claim Summary (PCS).

The member cannot be billed for these denied services. Blue Essentials, Blue Advantage HMO. and Blue Premier physicians, professional providers, facility and ancillary providers may not seek payment from
Please ensure that statements are not sent to **Blue Essentials, Blue Advantage HMO and Blue Premier** members, in accordance with the provisions of your **Blue Essentials, Blue Advantage HMO and Blue Premier** contract.
If an **Blue Essentials, Blue Advantage HMO and Blue Premier** physician, professional provider, facility or ancillary provider feels that a claim has been denied in error for untimely submission, **the Blue Essentials, Blue Advantage HMO and Blue Premier** physician, professional provider, facility or ancillary provider may submit a claim review request. The **Claim Review Form** and instructions are located further within this manual.

If a claim is returned to the **Blue Essentials, Blue Advantage HMO and Blue Premier** provider for additional information, it should be resubmitted to **Blue Essentials, Blue Advantage HMO and Blue Premier** within **180** days. The **180** days begin with the date **Blue Essentials, Blue Advantage HMO and Blue Premier** mails the request. If claims are filed electronically, then Blue Essentials, Blue Advantage HMO and Blue Premier physicians or professional providers must make the necessary corrections and refile the claim electronically in order for the claim to be processed.

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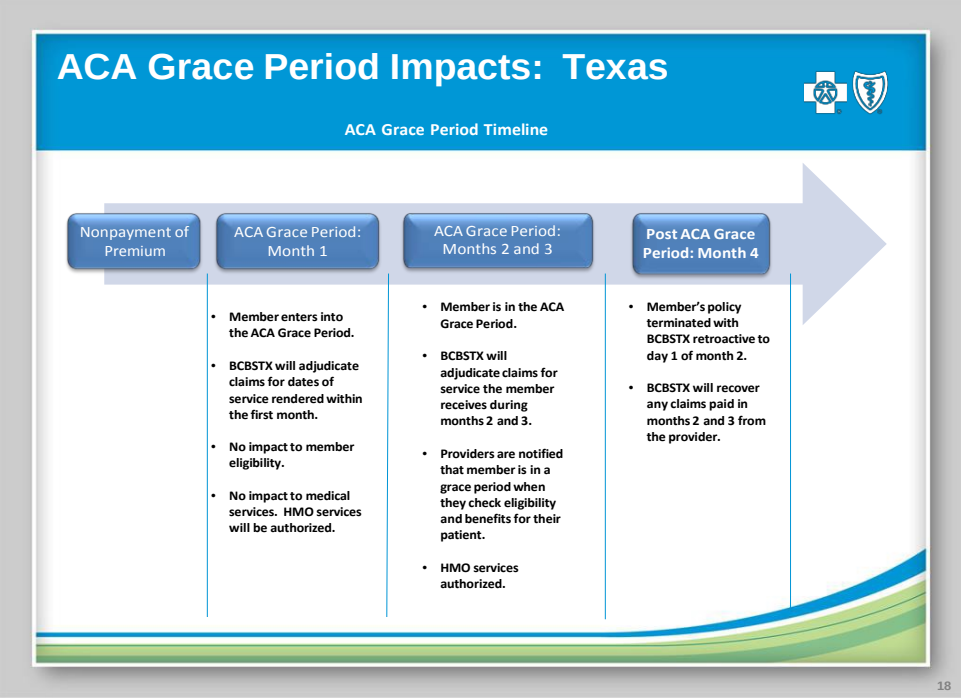
Blue Advantage HMO Only Grace Period

The **Affordable Care Act (ACA)** includes a provision that gives Health Insurance Marketplace members who receive **advanced premium tax credits (APTC**) also known as subsidies, a three-month grace period to pay their premium



Blue Essentials Only Grace Period

Standard 30 day grace period will apply for enrollees.

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Changes Affecting Your Provider Record ID - NPI Number Change, Name Change, Change in Address, etc

Report changes immediately – to your name, telephone number, address, NPI number(s), specialty type or group practice, etc.

1) To submit changes directly to BCBSTX by email, go to bcbstx.com/provider and click on the Network Participation tab, then scroll down to – Update Your Information – and complete/submit the **Provider Data Update Form**, or
2) by calling Provider Administration at **972-996-9610, press 3**, or
3) by contacting your Provider Relations office. For more detailed information, refer to **Section A - Support Services in the HMO Blue Texas, Blue Advantage HMO and Blue Premier Provider Manual.**

Keeping BCBSTX informed of any changes you make allows for appropriate claims processing, as well as maintaining the Blue Essentials and Blue Advantage HMO Provider Directory with current and accurate information.

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Prompt Pay

Blue Essentials, Blue Advantage HMO and **Blue Premier** complies with the Texas Prompt Pay Act. The Prompt Pay Act requres insurance carriers to pay clean claims that are subject to the Act's requirements within certain specified statutory payment periods. Insurance carriers that do not comply with Prompt Pay Act's standards may owe statutory penalties to the provider.

Prompt Pay Legislation - Penalty

Providers are eligible for statutory prompt pay penalties under the Texas Prompt Pay Act only when certain requirements are met, including:

- Claim is made for subscriber of plan that is fully insured by BCBSTX
- The patient's insurance plan is regulated by the Texas Department of Insurance (TDI);
- The claim is submitted to **Blue Essentials, Blue Advantage HMO** and **Blue Premier** as a clean claim;
- The provider files the claim by the statutory filing deadline;
- The provider is a contracting preferred provider, and
- The services billed on the claim are payable.

Blue Essentials, Blue Advantage HMO and **Blue Premier** proactively monitors the timeliness of its payments for eligible claims and issues penalties to providers when it determines penalties are owed. If you believe statutory penalties are due and have not received a penalty payment from **Blue Essentials, Blue Advantage HMO** and **Blue Premier**, you may request review of penalty eligibility by contacting **Blue Essentials, Blue Advantage HMO** and **Blue Premier** Provider Customer Service at **800-451-0287**.

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Prompt Pay Legislation - Definition of a Clean Claim

In order to be eligible for Prompt Pay penalties, providers must submit a clean claim. A clean claim includes all the data elements specified by the TDI in prompt pay rules or applicable electronic standards. Each specified data element must be legible, accurate, and complete.

For non-electronic submissions by institutional providers, a claim should be submitted using the Centers for Medicare and Medicaid Services (CMS) Form UB-04.[1] The UB-04 claim form must include all the required data elements set forth in TDI rules,[2] including, if applicable, the amount paid by the primary plan.[3]

For non- electronic submissions by professional providers, a claim shall be submitted on a CMS Form 1500(02/12) claim form.

Electronic claims by professional or institutional providers must be submitted using the ASC X12N 837 format in order to be considered a clean claim. Providers must submit the claim in compliance with the Federal Health Insurance Portability and Accountability Act (HIPAA) requirements related to electronic health care claims, including applicable implementation guidelines, companion guides, and trading partner agreements.[4]

A claim that does not comply with the applicable standard is a deficient claim and will not be penalty eligible.[5] When **Blue Essentials, Blue Advantage HMO** and **Blue Premier** are unable to process a deficient claim, it will notify the provider of the deficiency and request the correct data element.

At times, deficient claims contain sufficient information for BCBSTX's adjudication and payment. Rather than requiring the provider to correct the deficiency before payment is issued, BCBSTX considers it in the best interest of providers to pay deficient claims as soon as possible. However, because deficient claims are not clean claims, they are not eligible for penalties even if BCBSTX pays the claim outside of the applicable payment period.[6]

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1 Ex. C, Tex. Ins. Code § 1301.131(b).
2 Ex. B, 28 Tex. Admin. Code § 21.2803(b)(3).
3 Ex, B, 28 Tex. Admin. Code § 21.2803(d)(1).
4 Ex. B, 28 Tex. Admin. Code § 21.2803(e)
5 Ex. D, 28 Tex. Admin. Code § 21.2802(10)
6 Ex. E, Report on the Activities of the Technical Advisory Committee on Claims Processing (Sep. 2004), at pp. 6-7.

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Prompt Pay Legislation - Statutory Claim Payment Periods

When a contracting provider submits a clean claim that meets all the requirements for Texas Prompt Pay Act coverage, the insurer must pay the claim within 30 days if it was submitted in electronic format and within 45 days if it was submitted in non-electronic format.[7] If a claim is deficient, the statutory period does not commence unless and until the provider corrects the unclean data element(s). The payment period for clean corrected claims is determined by the format of the corrected submission, without regard to the manner in which the original claim was received.

Blue Essentials, Blue Advantage HMO and **Blue Premier** may extend the applicable statutory payment by requesting additional information from the treating provider within thirty days of receiving a clean claim.[8] Such a request suspends the payment period until the requested response is received.[9] **Blue Essentials, Blue Advantage HMO** and **Blue Premier** must then pay any eligible charges within the longer of (1) fifteen days, or (2) the number of days remaining in the original payment period at the time the request was sent.[10]

Prompt Pay Legislation - Statutory Penalty Amounts

There are three (3) tiers of penalty calculation under the Texas Prompt Pay Act, depending on when the claim was paid. For claims submitted by institutional providers, half of the amount calculated in each tier is owed to the provider and the other half is owed to the Texas Department of Insurance.[11]

Tier 1: For payments 1 - 45 days late, the total penalty is equal to 50 percent of the difference between the billed charges and the contracted rate.[12]

Tier 2: For payments 46 – 90 days late, the total penalty is equal to 100 percent of the difference between the billed charges and the contracted rate.[13]

Tier 3: For payments more than 90 days late, the total penalty is equal to the Tier 2 amount plus 18% annual interest on that amount, accruing from the date payment was due to the date the claim and penalty are paid in full.[14]

7 Ex. F, Tex. Ins. Code § 1301.103.
8 Ex. G, Tex. Ins. Code § 1301.1054(a)
9 Ex. G, Tex. Ins. Code § 1301.1054(b).
10 Ex. G, Tex. Ins. Code § 1301.1054(b).
11 Ex. H, Tex. Ins. Code § 1301.137(l).
12 Ex. H, Tex. Ins. Code § 1301.137(a).
13 Ex. H, Tex. Ins. Code § 1301.137(b).
14 Ex. H, Tex. Ins. Code § 1301.137(c).

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Coordination of Benefits and Patient's Share

Members 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.

This article is meant to assist physicians, professional providers, facility and ancillary providers in understanding the coordination of benefits clause from the contracting perspective.

The information contained in this article applies to member's health benefit policies issued by Blue Cross and Blue Shield of Texas (BCBSTX). Please note: some Administrative Services Only (self-funded) groups may elect not to follow the general Coordination of Benefit rules of BCBSTX.

When the member's health benefit policy is issued by another Blues plan, also known as the HOME plan, the Coordination of Benefit provision is administered by that HOME plan, not BCBSTX. Therefore, the member's HOME plan health benefit policy will control how Coordination of Benefits is applied for that member.

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 member is the amount showing on the BCBSTX Provider Claim Summary.

The primary carrier does not take into account the member'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 **Blue Essentials, Blue Advantage HMO and Blue Premier** Provider Customer Service:

Blue Essentials – 877-299-2377

Blue Advantage HMO – 800-451-0287

Blue Premier – 800-876-2583

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Prompt Pay Legislation - Coordination of Benefits

Coordination of benefits is necessary when more than one plan is responsible for claim payment. Claims that involve coordination of benefits are subject to special rules under the Texas Prompt Pay Act.

When providers are aware of multiple plans potentially involved in claim payment, information related to all applicable plans must be submitted in order for the claim to be clean. The Provider must submit the claim first to the primary plan and then to any secondary or tertiary plans. The order of payer responsibility is determined by TDI guidelines, which have adopted the uniform rules of the National Association of Insurance Commissioners (NAIC).[18]

When **Blue Essentials, Blue Advantage HMO** and **Blue Premier** are the secondary payer of a claim submitted in non- electronic format, the amount paid by the primary plan is a required data element and must be submitted in field 54 for the claim to be clean.[19] Thus, the applicable statutory payment period for a secondary plan does not begin unless and until it receives the primary plan's adjudication information.

In some cases, **Blue Essentials, Blue Advantage HMO** and **Blue Premier** acts as both the primary and secondary payer on a single claim. A claim submitted to the primary plan that includes all required secondary plan information is sufficient to allow processing under both policies. The secondary plan's Texas Prompt Pay Act payment period does not begin until the claim is adjudicated by the primary plan.

If **Blue Essentials, Blue Advantage HMO** and **Blue Premier** determines that a secondary plan has paid an amount owed by the primary plan in error, it may recover the amount of its overpayment from the primary plan or from the provider if it has already been reimbursed by the primary plan.[20] For purposes of calculating Texas Prompt Pay Act penalties for secondary claims, the contracted rate and billed charges are reduced in proportion to the percentage of the claim owed after the primary plan's payment.[21]

[18] Ex. J. 28 Tex Admin. Code § 3.3507.
[19] Ex. B, 28 Tex. Admin. Code § 21.2803(d)(1).
[20] Ex. K. K, Tex. Ins. Code § 1301.134(e)-(f).
[21] Ex. L, 28 Tex. Admin. Code 21.2815(e).

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Coordination of Benefits / Subrogation	**Blue Essentials, Blue Advantage HMO and Blue Premier** 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 physician, professional provider, facility or ancillary provider. Quite often physicians, professional providers, facility and ancillary providers treating a member are the first to learn about the potential for other coverage. Information such as motor vehicle accidents, work-related injuries, slips/falls, etc. should be communicated to **Blue Essentials, Blue Advantage HMO and Blue Premier** for further investigation. In addition, each physicians, professional providers, facility and ancillary provider shall cooperate with **Blue Essentials, Blue Advantage HMO and Blue Premier** 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. **Blue Essentials, Blue Advantage HMO and Blue Premier** contracted physicians, professional providers, facility and ancillary providers agreed to file claims and encounter information with **Blue Essentials, Blue Advantage HMO and Blue Premier** even if the physician, professional provider, facility and ancillary provider believes or knows there is a third party liability. **To contact Blue Essentials, Blue Advantage HMO and Blue Premier regarding:** • Coordination of benefits, call **888-588-4203** • Subrogation cases, call **800-582-6418**
Correct Coding	Use the appropriate CPT and ICD 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 (02/12) claim form when possible. When more than six services are provided, multiple CMS-1500 (02/12) claim forms may be necessary.

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Fraudulent Billing	**Blue Essentials, Blue Advantage HMO and Blue Premier** considers fraudulent billing to include, but not be limited to, the following: 1. deliberate misrepresentation of the service provided in order to receive payment; 2. deliberately billing in a manner which results in reimbursement greater than what would have been received if the claim were filed in accordance with **Blue Essentials, Blue Advantage HMO and Blue Premier** billing policies and guidelines; and/or 3. billing for services which were not rendered.
Services Rendered Directly By Physician, Professional, Facility or Ancillary Provider	If services are rendered directly by the physician or professional provider, facility or ancillary provider, the services must be billed by the physician, professional provider, facility or ancillary provider. However, if the physician, professional provider, facility or ancillary provider does not directly perform the service and the service is rendered by another provider, only the rendering provider can bill for those services. **Notes**: 1. This does not apply to services provided by an employee of an **Blue Essentials, Blue Advantage HMO and Blue Premier**, e.g. Physician Assistant, 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 Physician or professional provider. 2. The following modifiers should be used by the supervising physician when he/she is billing for services rendered by a Physician Assistant (PA), Advanced Practice Nurse (APN) or Certified Registered Nurse First Assistant (CRNFA): **AS Modifier:** A physician should use this modifier when billing on behalf of a PA, APN or CRNFA for services provided when the aforementioned 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 CRNFA for **non-surgical** services. *(Modifier SA is used when the PA, APN, or CRNFA is assisting with any other procedure that **DOES NOT** include surgery).*

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Billing for Non-Covered Services	In the event that **Blue Essentials, Blue Advantage HMO and Blue Premier** determines in advance that a proposed service is not a covered service, a physician, professional provider, facility or ancillary provider must inform the Member in writing in advance of the service rendered. The Member must acknowledge this disclosure in writing and agree to accept the stated service as a non-covered service billable directly to the Member. To clarify what the above means - if you contact **Blue Essentials, Blue Advantage HMO and Blue Premier** and find out that a proposed service is not a covered service - you have the responsibility to pass this along to your patient (our Member). This disclosure protects both you and the Member. The Member 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 **Blue Essentials, Blue Advantage HMO or Blue Premier** due to bundling or other claim edits may not be billed to Member even if the Member has agreed in writing to be responsible for such services. Such services **are** Covered Services but are **not payable services** according to **Blue Essentials, Blue Advantage HMO or Blue Premier** claim edits.

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Surgical Procedures Performed in the Physician's or Professional Provider's office	When performing surgical procedures in a non-facility setting, the physician or professional provider's reimbursement covers the services, equipment, and some of the supplies needed to perform the surgical procedure when a member receives these services in the physician's or professional provider's office. Reimbursement will be allowed for some supplies billed in conjunction with a surgical procedure performed in the physician's or professional provider's office. To help determine how coding combinations on a particular claim may be evaluated during the claim adjudication process, you may continue to utilize Clear Claim Connection™ (C3). C3 is a free, online reference tool that mirrors the logic behind BCBSTX's code-auditing software. Refer to the BCBSTX provider website at bcbstx.com/provider for additional information on gaining access to C3. Please note the physician and professional provider's reimbursement includes surgical equipment that may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the surgical equipment or DME vendor will be denied based on the fact that the global physician reimbursement includes staff and equipment.
Contracted Physician's, Professional Provider's, Facility or Ancillary Provider's Must File Claims	As a reminder, physicians, professional providers, facility and ancillary 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 physicians, professional providers, facility and ancillary providers contract with BCBSTX. Notwithstanding the foregoing, a provision of the American Recovery and Reinvestment Act changed HIPAA to add a requirement that if a patient self pays for a service in full and directs a physicians, professional providers, facility and ancillary providers to not file a claim with the patient's insurer, the physicians, professional providers, facility and ancillary providers 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.

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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 is 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 Blue Cross and Blue Shield of Texas/**Blue Essentials, Blue Advantage HMO and Blue Premier** Multiple Surgery Pricing Guidelines apply. These guidelines are located on our Provider website at bcbstx.com/provider/pdf/multiplesurgerylogic.pdf.

Untimed Billing Procedure CPT Codes

Only one unit should be reported per date of service for the CPT®′ codes listed in the link below. Blue Cross and Blue Shield of Texas adheres to CPT guidelines for the proper usage of these codes. Unless there are extenuating circumstances documented in your office notes – for example, multiple visits on the same day, BCBSTX will only allow one unit per date of service for these codes. The BCBSTX claims system includes logic to adjudicate these CPT codes to allow only one unit per day.

A list of codes are located on the BCBSTX provider website at bcbstx.com/provider/claims/untimed_billing.html.

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Proper Speech Therapy Biling

CPT® codes 92506, 92507 and 92508 are defined as "treatment of speech, language, voice, communication and/or auditory processing disorder; individual" in the CPT manual. Codes 92506, 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 92506, 92507 and 92508 per date of service. Blue Cross and Blue Shield of Texas (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.

Submission of CPT 99000 with Modifier 59

BCBSTX regularly evaluates the coding practices of physicians and other providers who submit claims for services. This includes issues such as bundling and use of CPT® modifiers.

BCBSTX recently studied use of Modifier 59 (Distinct procedural service) with submission of CPT 99000 *(handling and/or conveyance of specimen for transfer from the physician's office to a laboratory).* Because CPT 99000 is purely an administrative service and not a procedure, BCBSTX considers use of Modifier 59 for this code to be inappropriate. This inappropriate use of Modifier 59 results in override of a claim system edit that considers CPT 99000 incidental to any other service performed on that date of service, including CPT 36415 for routine collection of venous blood, and results in an overpayment. Please do not submit claims for CPT 99000 with Modifier 59.

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Care Coordination Services	BCBSTX recognizes the following Category I Current Procedural Terminology (CPT®) codes for billing care coordination services: 99487, 99488 and 99489. BCBSTX reimbursement will be subject to the maximum benefit limit specified in the member's benefit plan. CPT copyright 2010 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.
Urgent Care Center Services Billed Using CPT Code S9088	BCBSTX considers CPT® Code S9088 as a non-covered procedure; therefore no reimbursement will be allowed. CPT copyright 2010 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the AMA.

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Pass-Through Billing	Pass-through billing is not permitted by BCBSTX. Pass-through billing occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider. The performing provider should bill for these services unless otherwise approved by BCBSTX. BCBSTX does not consider the following scenarios to be pass-through billing: 1. The service of the performing provider is performed at the place of service of the ordering provider and is billed by the ordering provider, or 2. The service is provided by an employee of a physician, professional provider, facility or ancillary provider, e.g., Physician Assistant, Surgical Assistant, Advanced Practice Nurse, Clinical Nurse Specialist, Certified Nurse Midwife and Registered First Assistant, who is under the direct supervision of the ordering provider and the service is billed by the ordering provider.
Filing Claims Reminders	• BCBSTX will not accept any screen prints sent by physicians or professional providers that have been generated on the physician's , professional provider's, facility or ancillary provider's system. • All **Blue Essentials, Blue Advantage HMO and Blue Premier** physicians, professional providers, facility and ancillary providers are required to use their applicable NPI number when filing **Blue Essentials, Blue Advantage HMO and Blue Premier** claims. • If the **Blue Essentials, Blue Advantage HMO and Blue Premier** members gives a **Blue Essentials, Blue Advantage HMO or Blue Premi**er physician, professional provider, facility or ancillary provider the wrong insurance information, the **Blue Essentials, Blue Advantage HMO or Blue Premier** physician, professional provider, facility or ancillary provider must submit the EOB *(Explanation of Benefits)* from the other insurance carrier. This information must reflect timely filing and the **Blue Essentials, Blue Advantage HMO or Blue Premier** physician, professional provider, facility or ancillary provider must submit the claim to BCBSTX within **180** days from the date a response is received from the other insurance carrier.

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Paperless Claims Processing Overview

Electronic Data Interchange (EDI) refers to the process of submitting claims data electronically. This is sometimes referred to as "paperless" claims processing.

Using an automated claims filing system gives you more control over claims filed and is the first step in making your office paper-free.

Availity, L.L.C. - Patients. Not Paperwork® Overview

Availity optimizes the flow of information between health care professionals, health plans, and other health care stakeholders through a secure internet-based exchange. The Availity Health Information Network encompasses administrative and clinical services, supports both real-time and batch transactions via the web and electronic date interchange (EDI), and is HIPAA compliant.

Availity is the recipient of several national and regional awards, including Consumer Directed Health Care, A.S.A.P. Alliance Innovation, eHealthcare Leadership, Northeast Florida Excellence in IT Leadership, E-Fusion, Emerging Technologies and Healthcare Innovations Excellence (TERHIE), and AstraZeneca-NMHCC Partnership.

For more information, including an online demonstration, visit availity.com or call **800-AVAILITY (282-4548)**.

Electronic Remittance Advice (ERA)

BCBSTX can provide you with an Electronic Remittance Advice (ERA). ERAs are produced every weekday and include all claims (whether submitted on paper or electronically). This process allows you to automatically post payments to your patients' accounts.

If you are interested in this service, please contact your computer vendor to determine if they have the capability to process ERAs and if so, what format and version they support.

BCBSTX offers the ERA in the following formats and versions:

- **ANSI 835 version 5010 A1**

To obtain the specifications for receiving ERAs, please contact the Electronic Commerce Center at 1(800)746-4614 or under Electronic Commerce on the bcbstx.com/provider website.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Electronic Funds Transfer (EFT)	EFT is a form of direct deposit that allows the transfer of Blue Cross and Blue Shield of Texas payments directly to a physician's, professional provider's, facility and ancillary provider's designated bank account. EFT is identical to other direct deposit operations such as paycheck deposits and can speed the reimbursement process. EFT payments are made every weekday. Adding the EFT capability can help you streamline your administrative processes. ***Electronic Funds Transfer is the fastest way an insurance company can pay a claim.*** If you need further information or have additional questions regarding EFT, contact the Electronic Commerce Center at 1(800)746-4614 or under Electronic Commerce on the bcbstx.com/ provider website.
Electronic Payment Summary (EPS)	Electronic Payment Summary (EPS) is an electronic print image of the Provider Claim Summary (PCS). It provides the same payment information as a paper PCS. It is sent the same day as your ERA. The paper PCS is discontinued 31 days after the provider enrolls in ERA.
Electronic Claim Submission & Payer Response Report	To ensure that electronic claims are received for processing, physicians, professional providers, facility and ancillary providers should review their Payer Response Reports after each transmission. To obtain the specifications on the Payer Response Reports options available to you, please contact your clearinghouse. If you are an Availity customer, contact Availity Client Services at **800-AVAILITY (282-4548)** or review their EDI Guide by clicking on the below link: **https://www.availity.com/documents/edi%20guide/edi_guide.pdf**

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Payer Response Reports

Blue Cross and Blue Shield of Texas supplies Payer Response Reports to our EDI Partners from the BCBS claims processing systems to submitters of electronic Blue Cross and Blue Shield of Texas claims. This report contains an individual **Document Control Number (DCN)** in the "Payer ICN" field of the response for each claim accepted. The report is forwarded within 48 hours after transmission is received and can be used as proof of claim receipt within our claims processing system for Blue Cross, Blue Shield, Blue Essentials, Blue Advantage HMO, FEP and BlueCard claims.

The DCN is significant in that electronic claims can now be traced back to the actual claim received into our claims processing system. An example of a DCN number is 60745D26102X. The first four digits of the DCN indicate the date: 6 (year=2016), 074 (Julian date=March 15). The final digit of the number "X" indicates an electronic claim.

You may see "Informational/Warning" messages on these reports. These messages are generated by the claim application; but, no action is necessary at this time. The claim will either be processed or you will receive a letter notifying you the claim must be resubmitted.

The Document Control Number information and the detailed Payer Response Reports provide accepted and rejected claims and give physicians and professional providers the tools they need to track their Blue Cross and Blue Shield of Texas electronic claims.

System Implications

If a claim should be rejected, you will need to correct the error(s) and resubmit the claim electronically for processing. To ensure faster turnaround time and efficiency, BCBSTX recommends that your software have the capability to electronically retransmit individually rejected claims.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

What are the Benefits of EMC/EDI?

- Turnaround time is faster for **Blue Essentials and Blue Advantage HMO** claims that are complete and accurate, and you are reimbursed more quickly, improving your cash flow. Claims filed with incomplete or incorrect information will either be rejected or suspended for further action.
- Your mailing and administrative costs are significantly reduced.
- Fewer claims are returned for information, saving your staff time and effort.
- Up-front claims editing reduces returned claims.
- You have more control of claims filed electronically. The data you submit electronically is imported into our claims processing system — there is no need for intermediate data entry.
- Make sure all corrected claims are refiled **electronically** with BCBSTX.
- You can transmit claims to our EDI Partners 24 hours a day, seven days a week.
- For support relating to electronic claims submission and/or other transactions available with Availity, please contact Availity Client Services at **800-AVAILITY (282-4548)**.
- The patient's account number appears on every Explanation of Payment you receive, which expedites posting of payment information.

Payer Identification Code

Blue Essentials, Blue Advantage HMO and **Blue Premier** physicians, professional providers, facility and ancillary providers submitting claims via the Availity Health Information Network must use payer identification code 84980. If you use another clearinghouse, please confirm that the correct electronic payer identifier for BCBSTX is used with your electronic claim vendor.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

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What Claims Can be Filed Electronically?

All Blue Cross and Blue Shield of Texas claims including:

- Out-of-state
- **Blue Essentials, Blue Advantage HMO and Blue Premier** *(including Encounters for **Blue Essentials** only)*
- Blue Cross and Blue Shield secondary claims
- Corrected and replacement claims
- All claim types may be filed electronically

iExchange Confirmation Number

If the **Blue Essentials, Blue Advantage HMO and Blue Premier** member is referred to a Specialty Care Physician or professional provider via the iExchange system or by the Utilization Management Department, the iExchange confirmation number or the Utilization Management Department's authorization number must be entered on an electronic or paper claim.

Electronic submission — Enter the authorization number in REF 2300 - Prior Authorization, REF01=G1, REF02=Prior Authorization number.

Paper submission – enter the authorization number in Block 23 on the **CMS-1500** (02/12) Claim Form.

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
How Does Electronic Claim Filing Work?	There are several ways to submit your claims data electronically: • You may submit ALL claims directly to Availity. This network is designed to be easily integrated into the software system typically used in physician or professional provider offices. A list of approved software vendors can be obtained by contacting the Availity Client Services **800-AVAILITY (282-4548)** or by visiting the Availity website at availity.com. • You can submit BCBSTX claims through most major electronic clearinghouses. • You may work through a software vendor who can provide the level of system management support you need for your practice, or you may choose to submit claims through a clearinghouse. • You may choose to have a billing agent or service submit claims on your behalf.
Submit Secondary Claims Electronically	**Blue Essentials, Blue Advantage HMO and Blue Premier** secondary claims can be submitted electronically. To do so requires NO explanation of benefits; however, all prior payer payment information must be included in the appropriate loops and segments and the electronic claim submitted to BCBSTX. All **Blue Essentials, Blue Advantage HMO or Blue Premier** rules for referral notification and preauthorization/precertification requirements must be followed.
Duplicate Claims Filing is Costly	In many instances we find that the original claim was submitted electronically and receipt was confirmed as accepted. Physicians or professional providers who have an automatic follow up procedure should not generate a paper or electronic "tracer" prior to 30 days after the original claim was filed. It is important to realize that submitting a duplicate tracer claim on paper or electronically will not improve the processing time. This acts only to delay processing, as the follow up claim will be rejected as "a duplicate of claim already in process".
Submit Encounter Data Electronically	**Blue Essentials, Blue Advantage HMO and Blue Premier** claims and encounter data can be submitted electronically by following a few simple guidelines. On the next page are the specific data elements, which are required to process **Blue Essentials, Blue Advantage HMO and Blue Premier** claim/encounter submission data

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

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Submit Encounter Data Electronically, cont'd

Extended NSF	ANSI		
(AA∅-04.∅)	BHTO6 or BHTO7	=	'RP' designates Encounter data only. All other values will be handled as claims
(AA∅-18.∅)	NM109(40) position 1	=	G
Payer ID (AA∅-17. ∅)	NM109(40) Positions 2-6	=	84980
Plan Route Code (DA∅-18.∅)	NM109 (IL/QC) positions 1-2	=	"ZGA" (First 3 positions) Not Required
Member Number (DA∅-18.∅)	NM109 (IL/QC Positions 3-13	=	11 digits Example: 123456789-02 (Enter the member number exactly as it appears on the Member ID ard)
Blue Essentials Group Number (DA∅-10.∅)	SBR03	=	Indicated on the ID card
Blue Shield Provider Number (BA∅-∅2. ∅) and 14.∅)	PRV03(B1)	=	BCBSTX 6-digit ID number
Blue Shield Rendering Provider Number (FA∅-23. ∅) Required on Group Practices only	NM109(82)	=	BCBSTX 6-digit number in 8XXXXX format
Prior Authorization Number (DA∅-14. ∅∅-14. ∅	REF02(GI)	=	Requires entry of "On Call" for On Call Physician/Provider
Specialty Care Physicians/Providers (DA∅-14. ∅	REF02(GI)	=	Authorization Number

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Submit Encounter Data Electronically, cont'd	The primary differences between a Blue Cross and Blue Shield of Texas claim and an HMO claim is the length of the patient's member ID number. The HMO member ID number is an 11-digit number. This number should be taken directly from the patient's ID card. The last two digits of the member ID number indicate the number assigned to each enrolled dependent under the member. The values for the last two digits range from 00 to 99. To insure accurate processing, claims received electronically should include the full 11-digit member number.
Providers with Multiple Specialties	If you have obtained a unique Organization ***(Type 2)*** NPI 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, and area 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 (WPC) 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.*

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Addresses for Claims Filing & Customer Service Phone Numbers

The member's ID card provides claims filing and customer service information. If in doubt, please call **Blue Essentials, Blue Advantage HMO and Blue Premier** Provider Customer Service at the numbers listed below. Although the submission of claims electronically is the preferred method, when a paper claim is submitted, use the appropriate address indicated below

Plan / Group	Claims Filing Address
Blue Essentials – 877-299-2377 **Blue Advantage HMO –** 800-451-0287 **Blue Premier –** 800-876-2583	P.O. Box 660044 Dallas, TX 75266-0044
BCBSTX Employees and Dependents 888-662-2395	P.O. Box 660044 Dallas, TX 75266-0044

Note: *If an **Blue Essentials** member's primary care physician is affiliated with a capitated Independent Practice Association (IPA) or Medical Group, claims for certain types of services must be submitted to the IPA or Medical Group, rather than to the normal address used for BCBSTX claims. If a claim should have been sent to an IPA or Medical Group, but was submitted to the **Blue Essentials** address, the claim will be rejected and you will receive notice to re-file it with the appropriate IPA or Medical Group.* Types of services that should be submitted to the IPA or Medical Group include the following:

- Physician Services
- Outpatient diagnostic testing services

To determine the appropriate IPA or Medical Group for claims submission, refer to the **Blue Essentials** member's ID card to obtain the Physician Organization (POrg) code and then refer to the table on page F-31 for the claims filing address. This table provides claims filing information for the capitated IPAs and Medical Groups in the Greater Houston area.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Blue Essentials **IPA / Medical Group Listing** **Phone Numbers & Claims Addresses**			
Physician Organization Code (POrg)	**Capitated IPA/ Medical Group Name**	**IPA/Medical Group Claims Filing Address**	**IPA/Medical Group Claims Inquiry and UM Phone Numbers**
KELS	Kelsey-Seybold Clinic	Kelsey-Seybold Clinic Claims Administration P.O. Box 841209 Pearland, TX 77584	713-442-5440 Claims 713-442-5339 UM
RNPO	Renaissance Physician Organization	Renaissance Physician Organization P. O. Box 2888 Houston, TX 77252-2888	832-553-3300 Claims 832-553-3333 UM or 800-280-8888

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

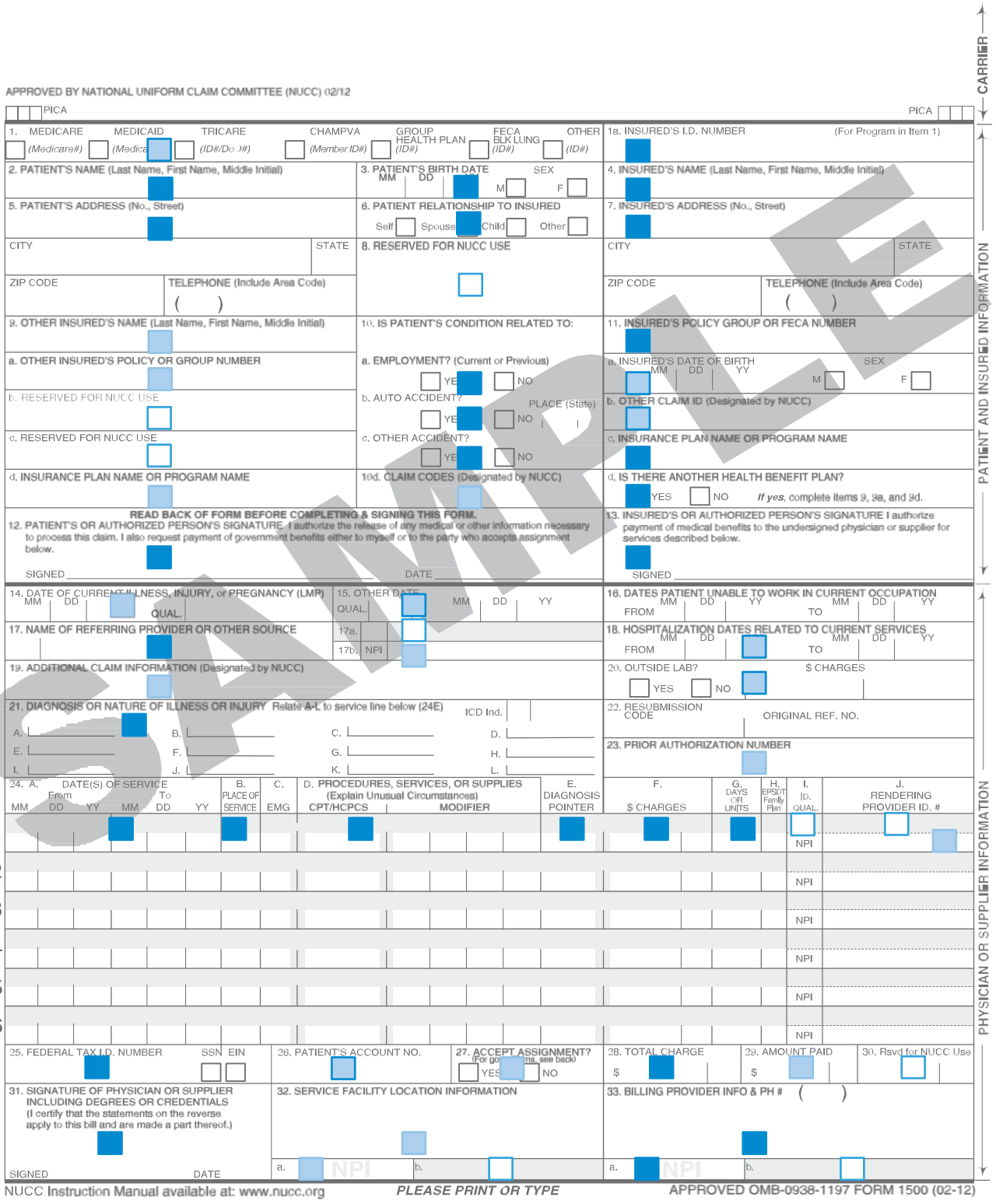
Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
CMS-1500 (02/12) Claim Form Introduction	**Blue Cross and Blue Shield of Texas (BCBSTX)** requires a **CMS-1500** (02/12) Claim form as the only acceptable document for participating physicians and professional providers *(except hospitals and related facilities)* for filing paper claims. Detailed instructions and a sample of the CMS-1500 (02/12) Claim form can be found on the following pages. Note that each field on the form is numbered. The numbers in the instructions correspond to the numbers on the form and represent the National Standard Specifications for electronic processing.
Ordering Paper Claim Forms	***Electronic claim filing is preferred,*** but if you must file a paper claim, you will need to use the standard CMS-1500 (02/12) Claim form. Obtain claim forms by calling the American Medical Association at: **800-621-8335**
Required Elements for Clean Claims	Blue Cross and Blue Shield of Texas requires all physicians or professional providers of health care services to file paper claims utilizing the **CMS-1500** (02/12) or **UB-04** forms, and electronic claims using National Standard Format (NSF), American National Standards Institute (ANSI 837) or UB-04 format. ALL paper claims for health care services MUST be submitted on one of these forms/formats. All claims must contain accurate and complete information. If a claim is received that is not submitted on the appropriate form or does not contain the required data elements set forth in Texas Department of Insurance Rules for Submission of Clean Claims and such other required elements as set forth in this Provider Manual and/or **Blue Essentials, Blue Advantage HMO and Blue Premier** provider bulletins or newsletters, the claim will be returned to the physician or professional provider/submitter with a notice of why the claim could not be processed for reimbursement. Please contact **Blue Essentials, Blue Advantage HMO or Blue Premier** Provider Customer Service for questions regarding paper or electronically submitted claims at the following phone numbers: **Blue Essentials** – 877-299-2377 **Blue Advantage HMO –** 800-451-0287 **Blue Premier –** 800-876-2583

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Return of Paper Claims with Missing NPI Number *(Texas only)*	Paper claims that do not have the NPI number listed correctly in the appropriate block on the claim form will be returned to the provider. To avoid delays, please list your billing provider identifier in block 33 on the standard **CMS-1500** (02/12) claim form.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

CMS 1500 Claim Form (02/12)



APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

CMS 1500 Claim Form (02/12 Key)

KEY

- R – TOI REQUIREMENT
- C – TOI CONDITIONAL ELEMENT
- B – DCE/DSX REQUESTED ELEMENT
- NUC – NOT REQUIRED/NOT USED

1. **TYPE OF HEALTH INSURANCE COVERAGE** R
Claim Editing Indicator—For services being billed to Blue Shield of Texas, place an "X" in the box marked (GROUP HEALTH PLAN). If the member has HMO or Commercial Insurance, select (OTHER)."

1a. **INSURED ID NUMBER** R
Enter the identification number found on the insured's BCBS ID card.

2. **PATIENT'S NAME** R Enter patient's Last name, First name, Middle initial, patient generation, (i.e., Jr., Sr.), if applicable.

3. **PATIENT'S BIRTH DATE/SEX** R
Enter patient's date of birth using an eight-digit date format (MM/DD/CCYY). Enter "X" in appropriate box to indicate patient's sex.

4. **INSURED'S NAME** R Enter insured's Last name, First name, Middle initial, patient generation, (i.e., Jr., Sr.), if applicable.

5. **PATIENT'S ADDRESS/TELEPHONE NUMBER** R
Enter patient's permanent mailing address and telephone number. Street, City, State, Zip Code.

6. **PATIENT'S RELATIONSHIP TO THE INSURED** R
Place an "X" in the appropriate box for patient's relationship to the insured.

7. **INSURED'S ADDRESS** R
Enter insured's Street, City, State, Zip Code (complete if different than patient's address).

8. **RESERVED FOR NUCC USE** NUC

9. **OTHER INSURED'S NAME** C
Enter other insured's Last name, First name, Middle initial, if applicable. When the patient has other insurance coverage complete 9 through 9d. This information is necessary to coordinate benefits with other insurance companies.

9a. **OTHER INSURED'S POLICY OR GROUP NUMBER** C
Enter group number, group name, Medigap Policy Number, Employee ID number of other insured.

9b. **RESERVED FOR NUCC USE** NUC
Other Insured's Date of Birth, Sex Enter other insured's date of birth using an eight-digit date format (MM/DD/CCYY). Enter "X" in appropriate box to indicate insured's sex.

9c. **RESERVED FOR NUCC USE** NUC
Enter other insured's employer.

9d. **INSURANCE PLAN NAME OR PROGRAM NAME** C
Enter other insured's group name.

10a-d. **IS PATIENT'S CONDITION RELATED TO:**

10a. **EMPLOYMENT:** For Employment Related Indicator, place an "X" in the appropriate box. R

10b. **AUTO ACCIDENT:** For Auto Accident Related Indicator, place an "X" in the appropriate box. If yes, enter the state in which the accident occurred. Use two-character abbreviation, i.e. TX. R

10c. **OTHER ACCIDENT:** For Other Accident Related Indicator, place an "X" in the appropriate box. R

10d. **CLAIM CODES (DESIGNATED BY NUCC)** C
If claim is a duplicate claim, a "7" is required. If claim is a corrected claim, a "C" is required.

(If this 10d, refer to BCBS subscriber coverage)

11. **INSURED'S POLICY GROUP OR FECA NUMBER** R
Enter the Group number from the subscriber's Blue Cross and Blue Shield Card.

11a. **INSURED'S DATE OF BIRTH, SEX** C
Enter insured's date of birth using an eight-digit date format (MM/DD/CCYY). Enter "X" in appropriate box to indicate patient's sex.

11b. **OTHER CLAIM ID (DESIGNATED BY NUCC)** C
Enter insured's employer or school.

11c. **INSURANCE PLAN NAME OR PROGRAM NAME** R
Enter name of insured's insurance plan, include name of state, i.e., Blue Shield of TX.

11d. **IS THERE ANOTHER HEALTH INSURANCE BENEFIT PLAN** R
Select whether there is another health insurance plan. Remember, if there is another health insurance plan, you will need to complete fields 9, 9a, and 9d. This information is necessary to coordinate benefits with other insurance companies.

12. **PATIENT OR AUTHORIZED PERSON'S SIGNATURE** R
Patient's or Authorized Person's Signature required but may indicate "Signature on File"

13. **INSURED OR AUTHORIZED PERSON'S SIGNATURE** R
Insured's or Authorized Person's Signature required but may indicate "Signature on File".

14. **DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)** C
Enter date using an eight-digit date format MM/DD/CCYY).

15. **OTHER DATE** C
Enter date using an eight-digit date format MM/DD/CCYY).

16. **DATES PATIENT UNABLE TO WORK: FROM DATE, TO DATE**
Enter date using an eight-digit date format MM/DD/CCYY), if applicable.

17. **NAME OF REFERRING PROVIDER OR OTHER SOURCE** R
Enter name (First, MI, Last name) and credentials of referring, ordering or supervising provider.
Note: If none, enter "self-referral" or "none."

17a. **OTHER ID#** NUC
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

17b. **NPI#** R
Enter the 10-digit NPI number of the referring, ordering or supervising provider.

18. **HOSPITALIZATION DATES RELATED TO CURRENT SERVICE: FROM DATE, TO DATE** R
Enter inpatient hospital admission date and discharge date using an eight-digit date format MM/DD/CCYY).

19. **ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)** C
Description for NDC or NDC required, if applicable.

20. **OUTSIDE LAB/CHARGES** B
If laboratory work was performed outside the physician's office, place an "X" in "yes" box and enter the total charges.

21. **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY** R
Enter the ICD-9-CM Codes. The primary diagnosis should be first, followed by other diagnoses.
Enter up to 4 ICD-9-CM Codes.

22. **RESUBMISSION**
Medicaid Resubmission Code.

23. **PRIOR AUTHORIZATION NUMBER** C
Required only if a Preauthorization or Verification is done.

24. **SHADED AREA – SUPPLEMENTAL INFORMATION –**
The shaded area of field 24a - 24h was created to accommodate supplemental information, i.e., Anesthesia. For more information, see the National Uniform Claim Committee's website at www.nucc.org.

24a. **DATE(S) OF SERVICE: FROM, TO** R
Enter the dates of service using an eight-digit date format MM/DD/CCYY).

24b. **PLACE OF SERVICE** R
Enter the appropriate 2 digit Place of Service code.

24c. **EMG**
Emergency Indicator – If for "Yes", leave blank if "No."

24d. **PROCEDURES, SERVICES, OR SUPPLIES** R
Enter the CPT or HCPCS code for the procedures, services or supplies and enter a modifier, if applicable.

24e. **DIAGNOSIS CODE** R
Enter one ICD-9-CM diagnosis code for each procedure performed. Enter only one code per line of service.

24f. **CHARGES** R
Enter charge for each line of service. This should be original charge not the balance due or patient liability. Do not include discounts.

24g. **DAYS OR UNITS** R
Enter number of days or units.

24h. **EPSDT/FAMILY PLAN**
For Early & Periodic Screening, Diagnosis and Treatment. Shaded area qualifiers:
S2 – Under Treatment, S1 – New Service Requested.

24i. **ID QUALIFIER - SHADED FIELD** NUC
Not required, reserved for taxonomy code qualifier, "ZZ."

24j. **RENDERING PROVIDER ID. #**

SHADED FIELD NUC
Not required, reserved for taxonomy code.

NON SHADED FIELD C
Enter performing provider 10-digit NPI number.

25. **FEDERAL TAX ID NUMBER** R
Enter the Federal Tax ID Number for the provider of service. Select the appropriate field for SSN or EIN.

26. **PATIENT ACCOUNT NUMBER** B
Enter account number assigned to the patient, if applicable.

27. **ACCEPT ASSIGNMENT** C
Enter "Yes" if the provider should be paid or enter "No" if the patient should be paid.

28. **TOTAL CHARGE** R
Enter total charges (total of all charges in 24f).

29. **AMOUNT PAID** C
Enter any amount paid by the patient.

30. **RSVD FOR NUCC USE** NUC
Enter the difference, if any, between the total charge and amount paid.

31. **SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDE DEGREES OR CREDENTIALS** R
The claim must be signed by the physician/supplier or an authorized representative. The form must also be dated using an eight-digit date format (MM/DD/CCYY).

32. **SERVICE FACILITY LOCATION INFORMATION** R
Enter location where services were rendered. According to Texas state law, this field is required if the services were performed somewhere other than the patient's home.

32a. **NPI** R
Enter the 10-digit NPI number of the service facility location.

32b. **PROVIDER ID#** NUC
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

33. **BILLING PROVIDER INFO AND PH#** R
Enter provider's or supplier's information that is requesting to be paid for services rendered.

33a. **NPI** R
Enter the 10-digit NPI number of the billing provider.

33b. **PROVIDER ID #** NUC
Not required, reserved for taxonomy code (preceded by "ZZ" qualifier).

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

CMS-1500 (02/12)

Place of Service Codes, Instructions & Examples of Supplemental Information in Item Number 24 and Reminders

Place of Service Codes

CODES	DEFINITIONS
01	Pharmacy
02	Unassigned
03	School
04	Homeless Shelter
05	Indian Health Service Free-standing Facility
06	Indian Health Service Provider-based Facility
07	Tribal 638 Free-standing Facility
08	Tribal 638 Provider-based Facility
09	Prison Correctional Facility
10	Unassigned
11	Office
12	Home
13	Assisted Living Facility
14	Group Home
15	Mobile Unit
16	Temporary Lodging
17	Walk-in Retail Health Clinic
18	Place of Employment-Worksite
19	Unassigned
20	Urgent Care Facility
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
25	Birthing Center
26	Military Treatment Facility
27-30	Unassigned
31	Skilled Nursing Facility
32	Nursing Facility
33	Custodial Care Facility
34	Hospice
35-40	Unassigned
41	Ambulance (Land)
42	Ambulance (Air or Water)
43-48	Unassigned
49	Independent Clinic
50	Federally Qualified Health Center
51	Inpatient Psychiatric Facility
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Mentally Retarded
55	Residential Substance Abuse Treatment Center
56	Psychiatric Residential Treatment Center
57	Non-residential Substance Abuse Treatment Facility
58-59	Unassigned
60	Mass Immunization Center
61	Comprehensive Inpatient Rehabilitation Facility
62	Comprehensive Outpatient Rehabilitation Facility
63-64	Unassigned
65	End-Stage Renal Disease Treatment Facility
66-70	Unassigned
71	Public Health Clinic
72	Rural Health Clinic
73-80	Unassigned
81	Independent Laboratory
82-98	Unassigned
99	Other Place of Service

Note: For more information on Place of Service Codes, see the National Uniform Claim Committee's website at www.nucc.org.

Instructions and Examples of Supplemental Information in Item Number 24

The following are types of supplemental information that can be entered in the shaded areas of Item Number 24:

- Narrative description of unspecified codes
- National Drug Codes (NDC) for drugs
- Contract rate
- Tooth numbers and areas of the oral cavity

The following qualifiers are to be used when reporting these services.

ZZ	Narrative description of unspecified code
N4	National Drug Codes (NDC)
CTR	Contract rate
JP	Universal/National Tooth Designation System
JO	ANSI/ADA/ISO Specification No. 3950-1984 Dentistry Designation System for Tooth and Areas of the Oral Cavity

For additional information for reporting NDC units, see the National Uniform Claim Committee's website at www.nucc.org.

Reminders

Complete all required fields. Make certain to enter the following identifying information:

- Put the insured's alpha prefix and identification number in Field 1a.
- Put the insured's policy group number in Field 11.
- Put the physician or supplier's billing name, address, ZIP code, telephone number and NPI number in Field 33.

The information required to file electronic claims is the same as for paper claims but there are major advantages to submitting electronic claims versus paper claims:

- You will reduce your overhead, electronically submitted claims can save hours of clerical time.
- You have better control and accuracy. Electronic claims are entered in the BCBSTX's system just the way they leave your office.
- You know when your claims are received because your office receives special reports detailing which claims were accepted. If there is a problem with your claim, you can correct it before the claim is processed.

To obtain more information on electronic claim filing, call 800-746-4614 or log on to bcbstx.com.

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Filing CMS-1500 Claims for Ancillary and Facility

Diabetic Education Center

The following table provides the applicable codes and descriptions used in coding Diabetic Education claims:

- Use **CMS-1500** (02/12) claim form
- Use POS "99" for the place of service
- Use diabetes as the primary ICD-10 diagnosis
- File with your NPI number

HCPCS Code	Descriptions
S9140	Diabetic Management Program Follow-up Visit to Non-MD Provider
S9145	Insulin Pump Initiation, Instructions in initial Use of Pump (pump not included)
S9455	Diabetic Management Program - Group Session
S9460	Diabetic Management Program – Nurse Visit
S9465	Diabetic Management Program – Dietician Visit
S9445	Patient Education, Not Elsewhere Classified, Non-Physician Provider, Individual, Per Session

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Durable Medical Equipment (DME)

HMO describes Durable Medical Equipment as being items which can withstand repeated use; are primarily used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury, or disease, and are appropriate for use in the patient's home.

DME Benefits

Benefits should be provided for the Durable Medical Equipment when the equipment is prescribed by a physician within the scope of his license and does not serve as a comfort or convenience item.

Benefits should be provided for the following:

1. Rental Charge (but not to exceed the total cost of purchase) or at the option of the Plan, the purchase of Durable Medical Equipment.
2. Repair, adjustment, or replacement of components and accessories necessary for effective functioning of covered equipment.
3. Supplies and accessories necessary for the effective functioning of covered Durable Medical Equipment

** Benefits are subject to the member's individual or group contract provisions.

Custom DME

When billing for "customized" Durable Medical Equipment (DME) or Prosthetic/Orthotic (P&O) devices, an item must be specially constructed to meet a patient's specific need. The following items do not meet these requirements:

- An adjustable brace with Velcro closures
- A pull-on elastic brace
- A light weight, high-strength wheelchair with padding added

A prescription is needed to justify the customized equipment and should indicate the reason the patient required a customized item. Physical therapy records or physician records can be submitted as documentation. An invoice should be included for any item that has been provided to construct a customized piece of DME or any P&O device for which a procedure code does not exist.

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Repair of DME	Repairs of DME equipment are covered if: • Equipment is being purchased or already owned by the patient, • Is Medically Necessary, and • The repair is necessary to make the equipment serviceable.
Replacement Parts	Replacement parts such as hoses, tubing, batteries, etc., are covered when necessary for effective operation of a purchased item.
DME Rental or Purchase	The rental versus purchase decision is between the patient and supplier. However, the rental of any equipment should not extend more than 10 months duration. If the prescription indicates "lifetime" need, the supplier should attempt to sell the equipment as opposed to renting.
DME Preauthori-zation	Preauthorization determines whether medical services are: • Medically Necessary • Provided in the appropriate setting or at the appropriate level of care • Of a quality and frequency generally accepted by the medical community DME > $2500.00 requires preauthorization for Blue Advantage HMO members ONLY. Predetermination for coverage is recommended for medical necessity determination in order to determine benefit coverage. Providers can fax completed Predetermination Forms to 1-888-579-7935 for urgent requests. **Note:** Failure to precertify may result in non-payment and providers cannot collect these fees from Blue Advantage HMO members. Precertification merely confirms the Medical Necessity of the service or admission, but does not guarantee payment. Payment will be determined after the claim is filed and is subject to the following: • Eligibility • Other contractual provisions and limitations, including, but not limited to: • Pre-existing conditions • Cosmetic procedures • Failure to call on a timely basis *(Prior delivery of CPM)* • Limitations contained in riders, if any

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DME Preauthorization, cont'd

- Payment of premium for the date on which services are rendered *(Federal Employee Participants are not subject to the payment of premium limitation)*

- Precertification may be obtained by calling:

  Blue Essentials – 800-441-9188 Blue Advantage HMO – 855-462-1785 Blue Premier – 800-441-9188

Prescription or Certificate of Medical Necessity

A prescription or Certificate of Medical Necessity (CMN) is required to accompany all claims for DME rentals or purchase. The prescription or CMN also must be signed by the member's attending physician.
When a physician completes an signs the CMN, he or she is attesting that the information indicated on the form is correct and that the requested services are Medically Necessary. The CMN must specify the following:

- Member's name
- Diagnosis
- Type of equipment
- Medical Necessity for requesting the equipment
- Date and duration of expected use

The Certificate of Medical Necessity is not required in the following circumstances:

- The claim is for an eligible prosthetic or orthotic device that does not require prior medical review;
- The place of treatment billed for durable medical equipment or supplies is inpatient, outpatient or office;
- The individual line item for durable medical equipment or supplies billed is less than $500.00 and the place of treatment is in the home or other;
- The claim is for durable medical equipment rental and is billed with the RR modifier; or
- The claim is for CPAP or Bi-Pap and there is a sleep study claim on file with BCBSTX that has been processed and paid. Sleep study CPT codes would be 95806-95811.

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Prescription or Certificate of Medical Necessity, cont'd

These guidelines apply to fully insured members as well as self-funded employer groups who have opted to follow these guidelines. However, this may not apply to members with Federal Employee Plan benefits or those from other Blue Cross and Blue Shield plans. To determine if a Certificate of Medical Necessity is required, please call the telephone number listed on the back of your patient's HMO member ID card.

Life-Sustaining DME

Life-Sustaining Durable Medical Equipment (DME) is paid as a perpetual rental during the entire period of medical need.

- The Vendor owns the DME. The vendor is responsible for monitoring the functional state of the DME and initiating maintenance or repair as needed. The vendor is likewise responsible for conducting the technical maintenance, repair and replacement of the DME. The rental payments to the vendor from BCBSTX cover these services.
- When the period of medical need is over, possession of the DME returns to the vendor.
- Attachments, replacement parts and all supplies and equipment ancillary to Life-Sustaining DME are considered included in the monthly rental payment. This includes refills of both gaseous and liquid oxygen.
- BCBSTX does not recognize or support member-owned DME previously obtained from another source.

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Life Sustaining DME List

HCPCS Code	Description BCBSTX Life Sustaining DME
E0424	Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mas, and tubing
E0434	Portable liquid oxygen system
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0450	Volume ventilator, ventilator, stationary or portable, w/backup rate feature, used w/invasive interface
E0460	Negative Pressure ventilator, portable or stationary
E0461	Volume control ventilator, without pressure support mode, may include pressure control mode, used with noninvasive interface (e.g. mask)
E0463	Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g. tracheostomy tube)
E0464	Pressure support ventilator with volume control mode, may include pressure control mode, used with noninvasive interface (e.g. mask)

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Life Sustaining DME List, cont'd

HCPCS Code	Description BCBSTX Life Sustaining DME
E0481	Intrapulmonary percussive ventilation system and related accessories
E0618	Apnea monitor, without recording feature
E0619	Apnea monitor, with recording feature
E1390	Oxygen concentrator, single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate
E1391	Oxygen concentrator, dual delivery port capable of delivering 85% or greater oxygen, each
E1392	Portable oxygen concentrator, rental
E1590	Hemodialysis machine
E1592	Automatic intermittent peritoneal dialysis system
E1594	Cycler dialysis machine for peritoneal dialysis
K0738	Portable gaseous oxygen system, rental; home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing
S8120	Oxygen contents, gaseous, 1 unit equals 1 cubic foot
S8121	Oxygen contents, liquid, 1 unit equals 1 pound

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Home Infusion Therapy (HIT)

- Please make sure all claims are filed with your NPI number electronically or on a **CMS-1500** (02/12) claim form.
- Use Place of Service 12 (Home) when filing your claim.
- A service found on the HIT schedule, as well as the drugs used, will require precertification.
  Note: All services/drugs that will be administered must be listed in the authorization or they will be denied.
- Hemophilia Health Services, a division of Accredo Health Group Inc., is the exclusive HMO provider for all Factor Products. HMO members should be directed to Accredo as the exclusive provider.

  The below list of "Factor Products" is also identified in the Home Infusion Therapy Drug Schedule posted on the BCBSTX Provider Website and is subject to change in accordance with the terms of the agreement.

  Factor Products: J7187, J7189, J7190, J7192, J7193, J7194, J7195, J7198

  The contact number for Accredo is **800-800-6606** – ask to speak to a pharmacist.

  Nursing Visits: For nursing visits, precertify CPT Codes 99601 and 99602.

  For extended visits, precertify CPT Code 99602.

- Always bill using a valid J-code for a drug and identify the appropriate number of units administered in Field 24g of the **CMS-1500** (02/12) form. For example, if the J-code defines the drug as 1 gram and you administer 20 grams, the CMS-1500 (02/12) form should reflect 20 units. Please note that J3490 should only be used if there is not a valid J-code for the administered drug, in which case you would then bill using J3490 and the respective NDC number.
- If billing for two or more concurrent therapies, use the appropriate modifiers:
  - SH - Second concurrent administered infusion therapy
  - SJ – Third or more concurrently administered infusion therapy
- Per diems not otherwise classified should only be precertified if the HIT services are not defined in an established per diem code.

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Home Infusion Therapy (HIT), cont'd

The per diem for aerosolized drug therapy (S9061) does not include the cost of the nebulizer. The nebulizer must be purchased or rented through a HMO contracted Durable Medical Equipment supplier.

- The HIT per diems include supplies and equipment. For example, IV poles, infusion pumps, tubing, etc. Refer below to a list of HCPCS codes that will be considered incidental to the per diem code.

Services Incidental to Home Infusion and Injection Therapy Per Diem

Miscellaneous Supplies and Services	
A4206-A4210 A4212-A4247 A4454-A4455	G0001 Q0081-Q0085 S9430
Vascular Catheters	
A4300-A4306	
Enteral Nutrition Medical Supplies	
B4034-B4086	
Parenteral Nutrition Solutions and Supplies	
B4164-B5200	
Enteral and Parenteral Pumps	
B9000-B9999	
Infusion Supplies	
E0776-E0830 K0455 S1015	

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Home Infusion Therapy Schedule

HCPCS Code	Description
	Nursing Services
99601	Home infusion/specialty drug administration, nursing services; per visit. Up to 2 hours.
99602	Home infusion/specialty drug administration, nursing services; each hour. *(List separately in addition to code 99601.)*
	Antibiotic Therapy
S9497	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 3 hours, administration services, professional pharmacy services, care coordination, and all necessary supplies and equipment (*drugs and nursing visits coded separately)*, per diem
S9500	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9501	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9502	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Antibiotic Therapy, cont'd
S9503	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 6 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9504	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 4 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
	Blood Transfusion
S9538	Home transfusion of blood product(s); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(blood products, drugs, and nursing visits coded separately)*, per diem
	Chemotherapy Infusion
S9329	Home infusion therapy, chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem *(Do not use this code with S9330 or S9331.)*
S9330	Home infusion therapy, continuous *(twenty-four hours or more)* chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
Chemotherapy Infusion, cont'd	
S9331	Home infusion therapy, intermittent *(less than twenty-four hours)* chemotherapy infusion; administration services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
Enteral Nutrition	
S9340	Home therapy, enteral nutrition; administrative services, professional services, care coordination, and all necessary supplies and equipment *(enteral formula and nursing visits coded separately)*, per diem
S9341	Home therapy, enteral nutrition via gravity; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(enteral formula and nursing visits coded separately)*, per diem
S9342	Home therapy, enteral nutrition via pump, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(enteral formula and nursing visits coded separately)*, per diem
S9343	Home therapy, enteral nutrition via bolus, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(enteral formula and nursing visits coded separately)*, per diem

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Hydration Therapy
S9373	Home infusion therapy, hydration therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and *equipment (drugs and nursing visits coded separately)*, per diem *(Do not use with hydration therapy codes S9374-S9377 using daily volume scales)*
S9374	Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and *equipment (drugs and nursing visits coded separately)*, per diem
S9375	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, car coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9376	Home infusion therapy hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9377	Home infusion therapy hydration therapy; more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Pain Management
S9325	Home infusion therapy, pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, *(drugs and nursing visits coded separately)*, per diem (*Do not use this code with S9326, S9327, or S9328)*
S9326	Home infusion therapy, continuous *(twenty-four hours or more)* pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9327	Home infusion therapy, intermittent *(less than twenty-four hours)* pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9328	Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem

Blue Essentials, Blue Advantage HMO and Blue Premier

Blue Premier Provider Manual - Filing Claims

Please Note

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Parenteral Nutrition
S9364	Home infusion therapy, total parenteral nutrition (TPN); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, including standard TPN formula *(lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately)* per diem *(Do not use with home infusion codes S9365- S9368 using daily volume scales)*
S9365	Home infusion therapy, total parenteral nutrition (TPN); one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, including standard TPN formula *(lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately)* per diem
S9366	Home infusion therapy, total parenteral nutrition (TPN); more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, including standard TPN formula *(lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately)*, per diem
S9367	Home infusion therapy, total parenteral nutrition (TPN); more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, including standard TPN formula *(lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately*), per diem

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Parenteral Nutrition, cont'd
S9368	Home infusion therapy, total parenteral nutrition (TPN); more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, including standard TPN formula *(lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately)*,
	Miscellaneous Infusion Therapy
S9061	Home administration of aerosolized drug therapy *(e.g., pentamidine)*; administrative services, professional pharmacy services, care coordination, all necessary supplies and *equipment (drugs and nursing visits code separately), per diem*
S9336	Home infusion therapy, continuous anticoagulant infusion therapy *(e.g., heparin)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded*
S9338	Home infusion therapy,immunotherapy;administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits*
S9345	Home infusion therapy, anti-hemophilic agent infusion therapy (e.g., Factor VIII); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9346	Home infusion therapy, alpha-1-proteinase inhibitor *(e.g., Prolastin)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Miscellaneous Infusion Therapy, cont'd
S9347	Home infusion therapy, uninterrupted, long-term, controlled rate intravenous infusion therapy *(e.g., epoprostenol)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and *equipment (drugs and nursing visits coded separately)*, per diem
S9348	Home infusion therapy, sympathomimetric/inotropic agent infusion therapy *(e.g., dobutamine)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9349	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9351	Home infusion therapy, continuous anti-emetic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)*, per diem
S9353	Home infusion therapy, continuous insulin infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9355	Home infusion therapy, chelation therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Miscellaneous Infusion Therapy, cont'd
S9357	Home infusion therapy, enzyme replacement intravenous therapy*; (e.g., imiglucerase)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9359	Home infusion therapy, anti-tumor necrosis intravenous therapy*; (e.g., inflixmab)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9361	Home infusion therapy, diuretic intravenous therapy*;* administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9361	Home infusion therapy, anti-spasmodic intravenous therapy*;* administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9363	Home infusion therapy, anti-spasmodic intravenous therapy*;* administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9370	Home therapy, intermittent anti-emetic injection therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
S9372	Home therapy, intermittent anticoagulant injection therapy *(e.g., heparin)*; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem *(Do not use this code for flushing of infusion devices with heparin to maintain patency)*

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Miscellaneous Infusion Therapy, cont'd
S9490	Home infusion therapy, corticosteroid infusion, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and visits coded separately)* per diem
	Not Otherwise Classified Infusion Therapy
S9537	Home therapy, hematopoietic hormone injection therapy *(e.g., erythropoietin, G-CSF, GM-CSF)*, administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment *(drugs and nursing visits coded separately)*; per diem
S9559	Home injectable therapy; interferon, including administration services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9379	Home infusion therapy, infusion therapy not otherwise classified; administration services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9542	Home injectable therapy; not otherwise classified, including administration services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, pe
S9810	Home therapy; professional pharmacy services for provision of infusion, specialty drug administration, and/or disease state management, not otherwise classified, per hour *(Do not use this code with any per diem code)*

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
	Injection Therapy
S9558	Home injectable therapy; growth hormone, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S9560	Home injectable therapy. Hormonal therapy *(e.g., leuprolide, goserelin)*, including administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
	Miscellaneous Services
S5035	Home infusion therapy, routine service of infusion device *(e.g., pump maintenance)*
S5036	Home infusion therapy, repair of infusion device *(e.g., pump repair)*
S5497	Home infusion therapy, catheter care/maintenance, not otherwise classified; includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem
S5501	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment *(drugs and nursing visits coded separately)*, per diem

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual Filing Claims

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Home Infusion Therapy Schedule, *cont'd*

HCPCS Code	Description
	Miscellaneous Services, cont'd
S5502	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment, (*drugs and nursing visits coded separately)*, per diem (*use this code for interim maintenance of vascular access not currently in use)*
S5517	Home infusion therapy, all supplies necessary for restoration of catheter patency or declotting
S5518	Home infusion therapy, all supplies necessary for catheter repair
S5520	Home infusion therapy, all supplies *(including catheter)* necessary for a peripherally inserted central venous catheter (PICC) line insertion
S5521	Home infusion therapy, all supplies *(including catheter)* necessary for a midline catheter insertion
S5522	Home infusion therapy, insertion of peripherally inserted central venous catheter (PICC) line, nursing services only *(no catheter or supplies included)*
S5523	Home infusion therapy, insertion of midline central venous catheter, nursing services only *(no catheter or supplies included)*
	Concurrent Therapy Modifiers
SH – Modifier	Second concurrently administered infusion therapy
SJ – Modifier	Third or more concurrently administered infusion therapy

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual Filing Claims

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Home Infusion Therapy Schedule, cont'd

HCPCS Code	Description
Enteral Parenteral Therapy	
B4185	Parenteral nutrition solution, per 10 grams LIPIDS
B5000	Parenteral nutrition solution, compounded
B5100	Parenteral nutrition solution, compounded
B5200	Parenteral nutrition solution, compounded
*No variation in pricing for above Managed Care.	
Blood Products	
P9051	Whole blood or red blood cells, leukocytes reduced, CMV-negative, each unit
P9052	Platelets, HLA-matched leukocytes reduced, apheresis/pheresis, each unit
P9053	Platelets, pheresis, leukocytes reduced, CMV-negtive, irradiated, each unit
P9054	Whole blood or red blood cells, leukocytes reduced, frozen, deglycerol, washed, each unit
P9055	Platelets, leukocytes reduced, CMV-negative, apheresis/pheresis, each unit
P9056	Whole blood, leukocytes reduced irradiated, each unit
P9057	Red blood cells, frozen/deglycerolized/washed, leukocytes reduced, irradiated, each unit
P9058	Red blood cells, leukocytes reduced, CMV-negative, irradiated, each unit
P9059	Fresh frozen plasma, between 8-24 hours of collection, each unit
P9060	Fresh frozen plasma, donor retested, each unit

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Imaging Centers

Filing CMS-1500 (02/12) Claims for Ancillary Facilities

File claims electronically with BCBSTX or submit **CMS-1500** (02/12)

- Must use CPT-4 coding structure
- Use POS "49" for place of service for electronic or paper claims
- Use the correct modifier appropriate to the service you are billing (i.e., total component, technical only, etc.)
- All not other classified procedure codes (NOCs) should be submitted with as much descriptive information as possible
- Must itemize all services and bill standard retail rates
- Must file with your NPI number
- Be sure to include NDC number for any oral or injectable radiopharmaceutical or contrast material used

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Imaging Center Tests Not Typically Covered

- **70371** – Complex dynamic pharyngeal and speech evaluation by cine or video recording
- **76000** – Fluoroscopy *(separate procedure)*, up to one hour physician time, other than 71023 or 71034
- **76140** – Consultation on x-ray examination made elsewhere, written report
- **76511** – Ophthalmic ultrasound, echography, diagnostic; A-scan only, with amplitude quantification
- **76513** – Contact B-scan *(with or without Simultaneous A-scan)*
- **76513** – Immersion *(water both)* B-scan
- **76516** – Ophthalmic biometry by ultrasound echography, A-scan
- **76519** – Ophthalmic biometry by ultrasound echography, A-scan with intraocular lens power calculation
- **76529** – Ophthalmic ultrasonic foreign body localization
- **76949** – Ultrasonic guidance for aspiration of ova, radiological supervision, and interpretation
- **78469** – Myocardial imaging, infarct avid, planar, qualitative or quantitative tomographic SPECT with or without quantitation
- **PET Scans**
- **77058–77079** – MRI of the breast

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual Filing Claims

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Independent Laboratory Claims Filing	• File claims electronically with BCBSTX or submit **CMS-1500** (02/12) • Use CPT-4 coding structure • Use place of service "81" • Must file with your NPI number • Must itemize all services and bill standard retail rates
Independent Laboratory Preferred Provider	Quest Diagnostics, Inc. is the ***exclusive statewide*** outpatient clinical reference laboratory provider for HMO members. This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries *(hospital and free standing ambulatory surgery centers)*. Quest Diagnostics, Inc. offers: On-line scheduling for Quest Diagnostics' Patient Service Center (PSC) locations. To schedule a PSC appointment, log onto www.QuestDiagnostics.com or call **888-277-8772**. Convenient patient access to over 220 patient service locations. 24/7 access to electronic lab orders, results, and other office solutions through *Care360® Labs and Meds*. For more information about Quest Diagnostics lab testing solutions or to setup an account, contact your Quest Diagnostics' Physician Representative or call **866-MY-QUEST**.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Independent Laboratory Policy

- All not otherwise classified procedure codes (NOCs) should be submitted with as much descriptive information as possible.
- "STAT" charges are not reimbursable as a separate line item.
- The following diagnostic tests are not routinely covered without sufficient medical justification:
    - Amylase, blood, isoenzyme, electrophoretic
    - Autogenous vaccine
    - Calcium, feces, screening
    - Calcium saturation clotting time
    - Cappillary fragility test (Rumpel-Leede)
    - Cephalin flocculation Congo red, blood
    - Chemotropism, duodenal contents
    - Chromium, blood
    - Circulation time, one test
    - Colloidal gold
    - Gastric analysis, pepsin
    - Gastric analysis, tubeless
    - Hormones, adrenocorticotropin, Quantitative, animal test
    - Hormones, adrenocorticotropin, Quantitative, bioassay
    - Skin test, lymphopathia verereum
    - Skin test, Brucellosis
    - Skin test, Leptospirosis
    - Skin test, Psittacosis
    - Skin test, Trichinodid
    - Thymol turbidity, blood
    - Zinc sulphate, turbidity, blood

- The following tests are the components of the Obstetrical (OB) Profile:
    - ABO type
    - Antibody screens for red cell antigens
    - CBC
    - RH type
    - Rubella titer
    - Serologic tests for syphilis
    - Sickle cell prep *(when appropriate)*

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Independent Laboratory – Non Covered Tests

- Appolipoprotein immunoassay testing (82172)
- Automated hemogram (85029, 85030)
- Candida enzyme immunoassay (CEIA) (00079)
- Captopril challenge test (00079)
- Cervigram (cervicography) (01055)
- Cystic disease protein test
- Cytomegalovirus screening in pregnancy patients
- EDTA formalin assay
- Glucose blood, stick test
- Glycated albumin test
- Human tumor stem cell drug sensitivity assay
- Lipoprotein cholesterol fractionation calculation by formula (83720)
- Neopterin RI acid test
- Nonprotein nitrogen (NPN) blood
- Provocative and neutralization testing for phenol and ethanol formaldehyde
- Radioimmunoassay (RIA) not otherwise specified
- RIA urinary albumin
- Sperm penetration assay
- Sublingual provocative testing
- Transfer factor test (86630)
- Travel allowance for specimen pickup
- Urinary albumin excretion rate

Prosthetics/Orthotics

- File claims electronically with BCBSTX or submit CMS-1500 (02/12)
- Must use HCPCS coding structure
- Must use place of service B
- Need to submit complete documentation when using an NOC procedure code
- Must itemize all services and bill standard retail rates
- Must file with your NPI number

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Prosthetics & Orthotics Non Covered

HCPCS Code	Description
N/A	Foot orthotics, bilateral
N/A	Foot orthotics, unilateral
N/A	Foot impressions, bilateral
N/A	Foot impressions, unilateral
N/A	Orthopedic Supports, cervical collar, immobolize slings
L0960	Torso support, post-surgical support, pads for post surgical
L0982	Stocking supporter grips, set of four Foot
L3000	Foot, insert, removable, molded to patient model "UCB" type
L3001	Foot, insert, removable, molded to patient model spenco, each
L3002	Foot, insert, removable, molded to patient model plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model silicone gel, each
L3010	Foot, insert, removable, molded to patient model longitudinal arch, each
L3030	Foot, insert. removable, formed to patient Foot
L3040	Foot, arch support, removable, pre-molded, longitudinal, each
L3050	Foot, arch support, removable, pre-molded, metatarsal, each
L3060	Foot, arch support, removable, pre-molded, longitudinal/metatarsal, each

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Prosthetics & Orthotics – Non Covered, cont'd

HCPCSCode	Description
L3070	Foot, arch support, non-removable attached to shoe, longitudinal, each
L3080	Foot, arch support, non-removable attached to shoe
L3090	Foot, arch support, non-removable attached to shoe, longitudinal/ metatarsal, each
L3100	Hallas-Valgus Night Dynamic splint
L3170	Foot, plastic heal stabilizer
L3201	Orthopedic shoe, oxford with Supinator or Pronator, infant
L3202	Orthopedic shoe, oxford with Supinator or Pronator, child
L3203	Orthopedic shoe, oxford with Supinator or Pronator, junior
L3204	Orthopedic shoe, high top with Supinator or Pronator, infant
L3206	Orthopedic shoe, high top with Supinator or Pronator, child
L3207	Orthopedic shoe, high top with Supinator or Pronator, junior
L3215	Orthopedic footwear, ladies shoes, oxford

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Prosthetics & Orthotics – Non Covered, cont'd

HCPS Code	Description
L3216	Orthopedic footwear, ladies shoes, depth inlay
L3217	Orthopedic footwear, ladies shoes, high top, depth inlay
L3219	Orthopedic footwear, men's shoes, oxford
L3221	Orthopedic footwear, men's shoes, depth inlay
L3222	Orthopedic footwear, men's shoes, high top, depth inlay
L3223	Orthopedic footwear, men's surgical boot, each
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each
L3251	Foot, shoe molded to patient model, silicone shoe, each
L3252	Foot, shoe molded to patient model, plastazote *(or similar)*, custom fabricated, each
L3253	Foot, molded shoe plastazote (*or similar)* custom fitted, each
L3254	Nonstandard size or width

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Prosthetics & Orthotics – Non Covered, cont'd

HCPCS Code	Description
L3255	Nonstandard size or length
L3260	Ambulatory surgical boot, each
L3265	Plastazote sandal, each
L3300	Lift, elevation, heel, tapered to metatarsals, per inch
L3310	Lift, elevation, heel and sole, Neoprene, per inch
L3320	Lift elevation, heel and sole, cork, per inch
L3330	Lift, elevation, metal extension (slate)
L3332	Lift elevation, inside shoe, tapered, up to one-half inch
L3334	Lift, elevation, heel, per inch
L3340	Heel, wedge, sock
L3350	Heel wedge
L3360	Sole wedge, outside sole
L3370	Sole wedge, between sole
L3380	Clubfoot wedge
L3390	Outflare wedge

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Prosthetics & Orthotics – Non Covered, cont'd

HCPCS Code	Description
L3430	Heel, counter, plastic reinforced
L3440	Heel, counter, leather reinforced
L3450	Heel, sock cushion type
L3455	Heel, new leather, standard
L3460	Heel, new rubber, standard
L3465	Heel, Thomas with wedge
L3470	Heel, Thomas extended to ball
L3480	Heel, pad and depression for spur
L3485	Heel, pad,removable for spur
L3500	Miscellaneous shoe addition, insole, leather
L3510	Miscellaneous shoe addition, insole, rubber
L3520	Miscellaneous shoe addition, insole, felt covered with leather
L3530	Miscellaneous shoe addition, sole half
L3540	Miscellaneous shoe addition, sole full
L3550	Miscellaneous shoe addition, toe tap, standard

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Prosthetics & Orthotics – Non Covered cont'd

HCPCS Code	Description
L3560	Miscellaneous shoe addition, toe tap, horseshoe
L3649	Unlisted procedures for foot orthopedic shoes, shoe modifications and transfers
A6530	Gradient compression stocking, below knee, 18-30 MMHG, each
A6531	Gradient compression stocking, below knee, 30-40 MMHG, each
A6532	Gradient compression stocking, below knee, 40-50 MMHG, each
A6533	Gradient compression stocking, thigh length, 18-30 MMHG, each
A6534	Gradient compression stocking, thigh length, 30-40 MMHG, each
A6535	Gradient compression stocking, thigh length, 40-50 MMHG, each
A6536	Gradient compression stocking, full length/ chap style, 18-30 MMHG, each
A6537	Gradient compression stocking, full length/ chap style, 30–40 MMHG, each
A6538	Gradient compression stocking, full length/ chap style, 40–50 MMHG, each

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Prosthetics & Orthotics – Non Covered, cont'd

HCPCS Code	Description
A6539	Gradient compression stocking, waist length, 18-30 MMHG, each
A6540	Gradient compression stocking, waist length, 30-40 MMHG, each
A6541	Gradient compression stocking, waist length, 40-50 MMHG, each
A6542	Gradient compression stocking, custom made
A6543	Gradient compression stocking, lymphedema
A6544	Gradient compression stocking, garter belt

Radiation Therapy Center Claims Filing

- Must use appropriate CMS claim form or electronic equivalent **Note:** Use UB-04 or electronic equivalent, if a facility; or Use CMS-1500 (02/12) if a free-standing facility
- Must bill negotiated rates according to fees stated in contract.
- May use CPT-4 code as part of description, but **must have correct** revenue codes if using UB-04.
- When the member's coverage requires a PCP referral, form locator 63 must be completed with a referral authorization number obtained from BCBSTX.
- Must file with your NPI number

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How to Complete the UB-04 Claim Form

The Uniform Bill (UB-04) is the standardized billing form for institutional services. HMO offers this guide to help you complete the UB-04 form for your patients with HMO (Facility) coverage. Refer to the sample form and instructions on the following pages.

For information on the UB-04 billing form, or to obtain an official UB-04 Data Specifications Manual, visit the National Uniform Billing Committee (NUBC) website at www.nubc.org.

Although electronic claim submission is preferred, institutional providers may submit claims in non-electronic format using the CMS Form UB-04. UB-04 is the required format for clean non-electronic claims by institutional providers under the Texas Prompt Pay Act. [22]

In order to be considered clean under the Texas Prompt Pay Act, claims submitted using the UB-04 must include all data elements specified by TDI rules.[23] The chart below details the data elements that are required and conditionally-required for clean claims submitted in this format. Claims that do not comply with these requirements will not be considered for prompt pay penalty eligibility.

The chart also provides the UB-04 data elements that BCBSTX has identified as potentially necessary for claim adjudication (highlighted in blue). Failure to submit these elements could result in payment delays as BCBSTX may need to request the information from the provider in order to adjudicate the claim.

Each data element in the chart below is identified by its corresponding field in the UB-04 claim form, along with the applicable rule and any additional detail needed to clarify the requirement. Each type of rule is defined by the following key:

R - TDI Requirement
C - TDI Conditional Element
B - BCBTX Requested Element

All claims must include all information necessary for adjudication of claims according to the contract benefits. For submission of paper claims, mail to the following address:

Blue Cross and Blue Shield of Texas

P.O. Box 660044
Dallas, TX 75266-0044

Note: Each field or block on the UB-04 claim form is referred to as a Form Locator.

What Forms are Accepted

The electronic ANSIX12N 837I-Institutional or the UB-04 claim form. A sample of the UB-04 is located on the next page.

[22] Ex. C, Tex. Ins. Code §1301.131(b).
[23] Ex.B, 28 Tex. Ins. Code §21.2803(b)(3).

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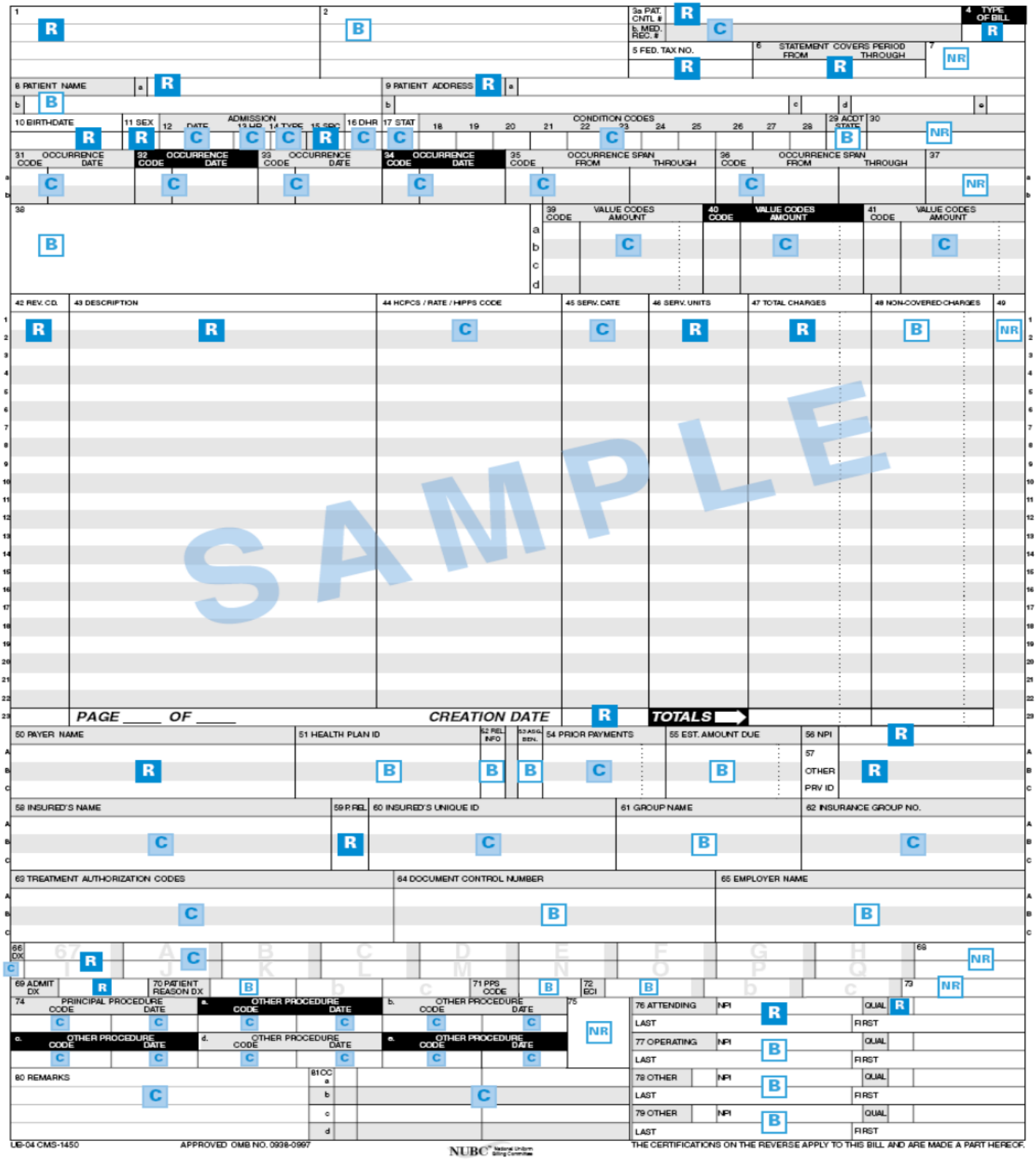
Sample UB-04 Form



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Procedure for Completing UB-04 Form

KEY

R = TDI REQUIREMENT
C = TDI CONDITIONAL ELEMENT
B = BCBSTX (HMO BLUE® TEXAS) REQUESTED ELEMENT
NR = NOT REQUIRED/NOT USED

1. **BILLING PROVIDER NAME, ADDRESS & TELEPHONE NUMBER - R**
Enter the billing name, street address, city, state, zip code and telephone number of the billing provider submitting the claim. Note: this should be the facility address.

2. **PAY TO NAME AND ADDRESS - B**
Enter the name, street address, city, state, and zip code where the provider submitting the claims intends payment to be sent. Note: This is required when information is different from the billing provider's information in form locator

3a. **PATIENT CONTROL NUMBER - R**
Enter the patient's unique alphanumeric control number assigned to the patient by the provider.

3b. **MEDICAL RECORD NUMBER - C**
Enter the number assigned to the patient's medical health record by the provider.

4. **TYPE OF BILL - R**
Enter the appropriate code that indicates the specific type of bill such as inpatient, outpatient, late charges, etc. For more information on Type of Bill, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

5. **FEDERAL TAX NUMBER - R**
Enter the provider's Federal Tax Identification number.

6. **STATEMENT COVERS PERIOD (From/Through) - R**
Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 010107.

7. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

8a. **PATIENT NAME/IDENTIFIER - R**
Enter the patient's identifier. Note: The patient identifier is situational/conditional, if different than what is in field locator 60 (Insured's/Member's Identifier).

8b. **PATIENT NAME - B**
Enter the patient's last name, first name and middle initial.

9. **PATIENT ADDRESS - R**
Enter the patient's complete mailing address (fields 9a – 9e), including street address (9a), city (9b), state (9c), zip code (9d) and country code (9e), if applicable to the claim.

10. **PATIENT BIRTH DATE - R**
Enter the patient's date of birth using an eight-digit date format (MMDDYYYY). For example: 01281970.

11. **PATIENT SEX - R**
Enter the patient's gender using an "F" for female, "M" for male or "U" for unknown.

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12. **ADMISSION/START OF CARE DATE (MMDDYY) - C**
Enter the start date for this episode of care using a six-digit format (MMDDYY). For inpatient services, this is the date of admission. For other (Home Health) services, it is the date the episode of care began.
Note: This is required on all inpatient claims.

13. **ADMISSION HOUR - C**
Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. **Required for all inpatient claims, observations and emergency room care.** For more information on Admission Hour, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

14. **PRIORITY (TYPE) OF VISIT - C**
Enter the appropriate code indicating the priority of this admission/visit. For more information on Priority (TYPE) of Visit, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

15. **POINT OF ORIGIN FOR ADMISSION OR VISIT - R**
Enter the appropriate code indicating the point of patient origin for this admission or visit. For more information on Point of Origin for Admission or Visit, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

16. **DISCHARGE HOUR - C**
Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. **Note: Required on all final inpatient claims**.

17. **PATIENT DISCHARGE STATUS - C**
Enter the appropriate two-digit code indicating the patient's discharge status.
Note: Required on all inpatient, observation, or emergency room care claims.

18-28. **CONDITION CODES - C**
Enter the appropriate two-digit condition code or codes if applicable to the patient's condition.

29. **ACCIDENT STATE - B**
Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.

30. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

31-34. **OCCURRENCE CODES/DATES (MMDDYY) - C**
Enter the appropriate two-digit occurrence codes and associated dates using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition.

35-36. **OCCURRENCE SPAN CODES/DATES (From/Through) (MMDDYY) - C**
Enter the appropriate two-digit occurrence span codes and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time.

37. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

38. Enter the name, address, city, state and zip code of the party responsible for the bill. **B**

39-41. **VALUE CODES AND AMOUNT - C**
Enter the appropriate two-digit value code and value if there is a value code and value appropriate for this claim.

42. **REVENUE CODE -**
Enter the applicable Revenue Code for the services rendered. For more information on Revenue Codes, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

43. **REVENUE DESCRIPTION - R**
Enter the standard abbreviated description of the related revenue code categories included on this bill. (See Form Locator 42 for description of each revenue code category.) **Note: The standard abbreviated description should correspond with the Revenue Codes as defined by the NUBC.** For more information on Revenue Description, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

44. **HCPCS/RATES/HIPPS CODE - C**
Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

45. **SERVICE DATE (MMDDYY) - C**
Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, SNF\PPS assessment date, or needed to report the creation date for line 23. **Note: Line 23 - Creation Date is Required.** For more information on Service Dates, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

46. **SERVICE UNITS - R**
Enter the number of units provided for the service line item.

47. **TOTAL CHARGES - R**
Enter the total charges using Revenue Code 0001. Total charges include both covered and non-covered services. For more information on Total Charges, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

48. **NON-COVERED CHARGES - B**
Enter any non-covered charges as it pertains to related Revenue Code. For more information on Non-Covered Charges, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

49. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

50. **PAYER NAME - R**
Enter the health plan that the provider might expect some payment from for the claim.

51. **HEALTH PLAN IDENTIFICATION NUMBER - B**
Enter the number used by the primary (51a) health plan to identify itself. Enter a secondary (51b) or tertiary (51c) health plan, if applicable.

52. **RELEASE OF INFORMATION - B**
Enter a "Y" or "I" to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier.

53. **ASSIGNMENT OF BENEFITS - B**
Enter a "Y", "N" or "W" to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider for the primary payer (53a). Enter a secondary (53b) or tertiary (53c) payer, if applicable.

54. **PRIOR PAYMENTS - C**
Enter the amount of payment the provider has received (to date) from the payer toward payment of the claim.

55. **ESTIMATED AMOUNT DUE - B**
Enter the amount estimated by the provider to be due from the payer.

56. **NATIONAL PROVIDER IDENTIFIER (NPI) - R**
Enter the billing provider's 10-digit NPI number.

57. **OTHER PROVIDER IDENTIFIER - R**
Required on or after the mandatory NPI implementation date when the 10-digit NPI number is not used FL 56.

58. **INSURED'S NAME - C**
Enter the name of the individual (primary – 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b and 58c).

59. **PATIENT'S RELATIONSHIP TO INSURED - R**
Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b and 59c).

60. **INSURED'S UNIQUE IDENTIFIER - C**
Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b and 60c).

61. **INSURED'S GROUP NAME - B**
Enter insured's employer group name (61a). If applicable, enter other insured's employer group names when other payers are known to be involved (61b and 61c).

62. **INSURED'S GROUP NUMBER - C**
Enter insured's employer group number (62a). If applicable, enter other insured's employer group numbers when other payers are known to be involved (62b and 62c). **Note: BCBSTX requires the group number on local claims.**

63. **TREATMENT AUTHORIZATION CODES - C**
Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).

64. **DOCUMENT CONTROL NUMBER (DCN) - B**
Enter if this is a void or replacement bill to a previously adjudicated claim (64a – 64c).

65. **EMPLOYER NAME - B**
Enter when the employer of the insured is known to potentially be involved in paying claims. For more information on Employer Name, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

66. **DIAGNOSIS AND PROCEDURE CODE QUALIFIER - C**
Enter the required value of "9". Note: "0" is allowed if ICD-10 is named as an allowable code set under HIPAA. For more information, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

67. **PRINCIPAL DIAGNOSIS CODE AND PRESENT ON ADMISSION (POA) INDICATOR - R**
Enter the principal diagnosis code for the patient's condition. For more information on POAs, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

67a-67q. **OTHER DIAGNOSIS CODES - C**
Enter additional diagnosis codes if more than one diagnosis code applies to claim.

68. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

69. **ADMITTING DIAGNOSIS CODE - R**
Enter the diagnosis code for the patient's condition upon an inpatient admission.

70. **PATIENT'S REASON FOR VISIT - B**
Enter the appropriate reason for visit code only for bill types 013X and 085X and 045X, 0516, 0526, or 0762 (observation room).

71. **PROSPECTIVE PAYMENT SYSTEM (PPS) CODE - B**
Enter the DRG based on software for inpatient claims when required under contract grouper with a payer.

72. **EXTERNAL CAUSE OF INJURY (ECI) CODE - B**
Enter the cause of injury code or codes when injury, poisoning or adverse affect is the cause for seeking medical care.

73. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

74. **PRINCIPAL PROCEDURE CODE AND DATE (MMDDYY) - C**
Enter the principal procedure code and date using a six-digit format (MMDDYY) if the patient has undergone an inpatient procedure. **Note: Required on inpatient claims.**

74a-e. **OTHER PROCEDURE CODES AND DATES (MMDDYY) - C**
Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure. **Note: Required on inpatient claims.**

75. Reserved for assignment by the NUBC. Providers do not use this field. **NR**

76. **ATTENDING PROVIDER NAME AND IDENTIFIERS - R**
Enter the attending provider's 10 digit NPI number and last name and first name. Enter secondary identifier qualifiers and numbers as needed. *Situational: Not required for non-scheduled transportation claims. For more information on Attending Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

77. **OPERATING PROVIDER NAME AND IDENTIFIERS - B**
Enter the operating provider's 10-digit NPI number, Identification qualifier, Identification number, last name and first name. Enter secondary identifier qualifiers and numbers as needed. For more information on Operating Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

78-79. **OTHER PROVIDER NAME AND IDENTIFIERS - B**
Enter any other provider's 10-digit NPI number, Identification qualifier, Identification number, last name and first name. Enter secondary identifier qualifiers and numbers as needed. For more information on Other Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

80. **REMARKS - C**
Enter any information that the provider deems appropriate to share that is not supported elsewhere.

81CC a-d. **CODE-CODE FIELD - C**
Report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. To further identify the billing provider (FL01), enter the taxonomy code along with the "B3" qualifier. For more information on requirements for Form Locator 81, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

Line 23. The 23rd line contains an incrementing page and total number of pages for the claim on each page, creation date of the claim on each page, and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

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Hospital Claims Filing Instructions - Outpatient

Following current standardized billing requirements for outpatient hospital services, CPT® and HCPCS codes will be required when the revenue codes listed below are used.

Revenue Code	Description
0261	IV Therapy; Infusion Pump
0274	Med/Surg Supplies - Prosthetic/Orthotic Devices
030X	Laboratory - Clinical Diagnostic
031X	Laboratory - Pathology
032X	Radiology - Diagnostic
033X	Radiology – Therapeutic
034X	Nuclear Medicine
035X	CT Scan
036X	Operating Room Services
038X	Blood: Packed Red Cells
0391	Blood Storage/Processing: Blood Administration
040X	Other Imaging Services
041X	Respiratory Services
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech Language Pathology
045X	Emergency Room
046X	Pulmonary Function
047X	Audiology
048X	Cardiology
049X	Ambulatory Surgery
051X	Clinic
052X	Free Standing Clinic
053X	Osteopathic Services
054X	Ambulance
0561	Medical Social Services: Visit Charge
0562	Medical Social Services: Hourly Charge
057X	Visit Charge
059X	Home Health – Units of Service
060X	Home Health – Oxygen
061X	Magnetic Resonance Tech (MRI)
0623	Surgical Dressings

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Hospital Claims Filing Instruct-ions – Outpatient, cont'd

Revenue Code	Description
0634	Drugs Require Specific ID: EPO under 10,000 Units
0635	Drugs Require Specific ID: EPO over 10,000 Units
0636	Drugs Require Specific ID: Drugs Requiring Detail Coding
064X	Home IV Therapy Services
065X	Hospice Service
067X	Outpatient Special Residence Charges
0722	Labor Room: Delivery
0723	Labor Room: Circumcision
0724	Labor Room: Birthing Center
073X	EKG/ECG
074X	EEG
075X	Gastrointestinal Services
0760	Treatment/Observation Room
0761	Treatment/Observation Room: Treatment Room
0769	Treatment/Observation Room: Other Treatment Room
077X	Preventative Care Services
078X	Telemedicine
079X	Extra-Corp Shock Wave Therapy
0811	Organ Acquisition: Living Donor
0812	Organ Acquisition: Cadaver Donor
0813	Organ Acquisition: Unknown Donor
0814	Organ Acquisition: Unsuccessful Organ Search Donor Bank Charges
083X	Peritoneal OPD/Home
084X	CAPD OPD/Home
085X	CCPD OPD/Home
088X	Miscellaneous Dialysis
090X	Psychiatric/Psychological Treatment
091X	Psychiatric/Psychological Services
092X	Other Diagnostic Services
0940	Other Therapeutic Services

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Hospital Claims Filing Instructions – Outpatient, cont'd

Revenue Code	Description
0941	Other Therapeutic Services; Recreation RX
0943	Other Therapeutic Serv: Cardiac Rehab
0944	Other Therapeutic Serv: Drug Rehab
0945	Other Therapeutic Serv: Alcohol Rehab
0946	Complex Medical Equipment - Routine

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Revenue Code and CPT / HCPCS Codes	The Revenue Code and CPT/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 in "The UB-04 Editor®", available from St. Anthony Publishing at 800-632-0123.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Hospital Claims Filing Instructions - Inpatient	The Hospitals in the HMO networks have agreed to: • Accept reimbursement for covered services on a negotiated price, DRG rates and/or per diems 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.
Type of Bill (TOB)	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 UB-04 manual for the valid codes.
NPI	Some facilities may have several NPI numbers (i.e., substance abuse wings, partial psychiatric day treatment). It is important to bill with the correct NPI for the service you provided or this could delay payment or even result in a denial of a claim.
Patient Status	The appropriate patient status is required on an inpatient claim. An incorrect patient status could result in inaccurate payments or a denial.
Occurrence Code / Date	All accident, emergency and maternity claims require the appropriate occurrence code and the date. Please refer to the UB-04 manual for the valid codes accepted by BCBSTX.
Late Charges / Corrected Claims	It is important to use the correct type of bill when billing for a late charge or a corrected claim. For inpatient 117 corrected claim For inpatient 115 late charges For outpatient 137 corrected claim For outpatient 135 late charges Corrected claims and late charges can be filed electronically. If the corrected claim must be filed on paper it should be submitted with a Corrected Claim Review Form.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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DRG Facilities	Interim bills are not accepted for claims process for DRG reimbursement. Late charges/credits are not accepted on DRG claims unless they will affect the reimbursement. The information used to determine a DRG: • All of the ICD-10 diagnoses billed on a claim • All of 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 – In no instance will the payment by the HMO for outpatient services be greater than the DRG rate would be if the service had been done on an inpatient basis. The only exception is outpatient admissions that are reimbursed by a case rate. If your facility provides the services of Radiation Therapy or Chemotherapy: • Bill Z510 for Radiation Therapy • Bill Z08, Z5111, or Z5112 Chemotherapy DRG cap will apply if you do not bill the above V codes as your primary diagnosis or if the above V codes as the primary diagnosis with revenue codes: 0762, (observation), 0481 (cardiac cath lab), 0450-0452 or 0459 (emergency room), 0456 (urgent care) or 0413 (hyperbaric therapy) and reimbursement is not a case rate. Refer to the Admission Type Hierarchy posted on the BCBSTX Provider website at www.bcbstx.com/provider under Reference Material.
Preadmission Testing	Preadmission tests provided by the Hospital within three (3) days of admission should be combined and billed with the inpatient claim.
Pre-Op Tests	For outpatient day surgery, services would be billed as one claim to include the day surgery and the pre-op tests.
Mother & Baby Claims	Claims for the mother and baby should be filed separately.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Clinic Charges

HMO does not reimburse facilities for Clinic Services, such as, professional services by emergency room physicians or physicians operating out of a clinic. These services are considered professional in nature, and would be billed under the physician's National Provider Identifier (NPI #). Billing professional charges on a UB-04 will generate a denial message instructing the physician to resubmit services on a CMS-1500 (02/12) form.

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

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 in order for the claim to be paid. The V code for the education/counseling would be listed as the secondary diagnosis.

Trauma

Trauma Defininition – ICD – 10 code must be in the Principal Diagnosis Field

Code	Description
800 – 992.9	For descriptions, refer to the ICD-10 Coding Book
993.2	Other and unspecified effects of high altitude
993.4	Effects of air pressure caused by explosion
994.0	Effects of lightening
994.1	Drowning and non-fatal submersion
994.7	Asphyxiation and strangulation
994.8	Electrocution and non-fatal effects of electric current
995.6 – 995.69	Anaphylactic shock due to adverse food reactions
996.9 – 996.99	Complication of reattached extremity or body part

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

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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 ("CMS").

Provider Based Billing Claim means the claim submitted with at least one service billed with National Uniform Billing Committee (NUBC) revenue codes 0510 – 0529 or with revenue codes 0760 – 0761 and E&M Office Visit CPT/HCPCS codes (including but not limited to 99201-99205, 99211-99215, 99241-99245, 99354, 99355, 99381-99387, 99391-99397, 99401-99411-99412, 99429, 99450, 99455-99456, 99487-99489, 99499).

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 UB04 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.

Provider Based Billing

Scenario 2: Split Billing With 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	99212	

Correct Billing

Physician Claim

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

Hospital Claim

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

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Scenario 3 – Split Billing With In Office Lab and Surgery

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	
	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	

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

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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 Compensation
	0300	80061	

Treatment Room Claim

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

Exception: claims with at least one Treatment Room service with E&M Office Visit Codes (including but not limited to 99201–99205, 99211-99215, 99241–99245, 99354, 99355, 99381 – 99387, 99391=99397, 99401-99411-99412., 99429. Note 99450, 99455-99456, 99487-99489, 99499 are not compensated by BCBSTX.

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

Exception: claims with at least one Treatment Room service with E&M Office Visit Codes (including but not limited to 99201–99205, 99211-99215, 99241–99245, 99354, 99355, 99381 – 99387, 99391=99397, 99401-99411-99412., 99429. Note 99450, 99455-99456, 99487-99489, 99499 are not compensated by BCBSTX.

Treatment Room Claim

Treatment Room and Diagnostic Services Claim Examples:

Treatment Room

Claim Example 1:

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	

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Hospital Claim

Type of Bill	Revenue Code	Procedure	Compensation
31 – Outpatient	0300	80053	Based on Contract Lab Compensation

Claim Example # 1

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	According to contracted outpatient rates
	0270	A6250	
	0300	80053	
	0300	80061	
	0761	36591	

Claim Example # 2

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0250	J1205	$0.00 Claim is considered Provider Based Billing

Diagnostic Claim

Type of Bill	Revenue Code	Procedure	Compensation
131 – Outpatient	0255	A9585	According to contracted outpatient rates
	0270	A6250	
	0300	80053	
	0300	80061	
	0611	70553	

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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DRG Carve Outs Prior to Grouper 25

DRG	Type
103	Transplant
302	Transplant
385 - 390	Neonate
424 - 432	Psychiatric
433	Substance Abuse
434 - 437	Substance Abuse *(not valid after Grouper 17)*
462	Rehabilitation
480 - 481	Transplant
495	Transplant
504 – 511	Burn
512 - 513	Transplant
521 - 523	Substance Abuse *(valid after Grouper 17}*

Please Note: Carve outs will be paid as designated in your contract.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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DRG Carve Outs for Grouper 25, 26 and 27

DRG	Type
001 - 002	Transplant
005 - 010	Transplant
652	Transplant
789 - 794	Neonate
876	Psychiatric
880 - 887	Psychiatric
894 – 897	Substance Abuse
927 – 929	Burn
933 - 935	Burn
945 – 946	Rehabilitation

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DRG Carve Outs for Grouper 28

DRG	Type
001 - 002	Transplant
005 - 008	Transplant
010	Transplant
014 - 015	Transplant
652	Transplant
789 - 794	Neonate
876	Psychiatric
880 - 887	Psychiatric
894 – 897	Substance Abuse
927 – 929	Burn
933 - 935	Burn
945 – 946	Rehabilitation

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DRG Carve Outs for Grouper 29

DRG	Type
001- 002	Transplant
005 – 008	Transplant
010	Transplant
014	Transplant
016 – 017	Transplant
652	Transplant
789 794	Neonate
945 – 946	Rehabilitation
876	Psychiatric
880 – 887	Psychiatric
894 – 897	Substance Abuse
927 – 929	Burn
933 – 935	Burn

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DRG Carve Outs For Grouper 30

DRG	Type
001 - 002	Transplant
005 – 008	Transplant
010	Transplant
014	Transplant
016 – 017	Transplant
652	Transplant
789 794	Neonate
945 – 946	Rehabilitation
876	Psychiatric
880 – 887	Psychiatric
894 – 897	Substance Abuse
927 – 929	Burn
933 – 935	Burn

Please Note: Carve-outs will be paid as designated in your contract

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Cardiac Cath / PTCA

NON OPPS

Procedure Code	Description
Cardiac Cath	
93451	Right Heart Catherization
93452	Left Heart Cath w/Ven
93453	R&L Heart Cath/Ventriclgrphy
93454	Coronary Artery Angio S&L
93455	Coronary Art/Graft Angio S&L
93456	R Hrt Coronary Artery Angio
93457	R Hrt Art/Graft Angio
93458	L Hrt Artery/Ventricle Angio
93459	L Hrt Art/Graft Angio
93460	R&L Hrt Art/Ventricle Angio
93461	R&L Hrt Art/Ventricle Angio
93462	L Hrt Cath Transptl Puncture
93503	Insertion & Placement of flow directed Cath (e.g., Swanz-Ganz for monitoring purpose)
93505	Endo Myocardial Biopsy
93530	Right Heart Cath, Congenital
93531	R&L Heart Cath, Congenital
93532	R&L Heart Cath, Congenital

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath	
93533	R & L heart cath, congenital
93563	Inject left vent/atrial angio
93564	Inject heart congenital art/graft
93565	Inject left ventr/atrial angio
93566	Inject R ventr/atrial angio
93567	Inject suprvlv aortography
93568	Inject pulm art heart cath
33207	Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular
33208	Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular
33210	Insertion or replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter *(separate procedure)*
33212	Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular
33213	Insertion or replacement of pacemaker pulse generator only; dual chamber
33223	Revision of skin pocket for single or dual chamber pacing cardioverter-defibrillator

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath, cont'd	
33233	Removal of permanent pacemaker pulse generator
33240	Insertion of Single or Dual Chamber Pacing Cardioverter-Defibrillator Pulse Generator
33241	Subcutaneous Removal of Single or Dual Chamber pacing Cardioverter-Defibrillator Pulse Generator
33249	Insertion or Repositioning of Electrode Lead(s) for Single or Dual Chamber Pacing Cardioverter-Defibrillator & Insertion of Pulse Generator
33249	Insertion or Repositioning of Electrode Lead(s) for Single or Dual Chamber Pacing Cardioverter-Defibrillator & Insertion of Pulse Generator
35311	Thromboendarterectomy, with or without patch graft; subclavian, innominate, by thoracic incision
35663	Insertion Tunneled CVC with Port
36002	Injection of Thrombin
36005	Injection procedure for extremity venography *(including introduction of needle or intracatheter)*
36010	Introduction of Catheter, Superior or Inferior Vena Cava

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath, cont'd	
36011	Selective cath placement; venous, 1st order
36012	Selective cath placement; venous, 2nd order
36100	Introduction of catheter, carotid
36120	Introduction of catheter, brachial artery
36140	Introduction of needle or intracatheter; extremity artery
36160	Introduction of needle/sheath, aortic
36200	Introduction of catheter, aorta
36215	Selective catheter placement, arterial system; each 1st order thoracic or brachiocephalic branch within a vascular family
36216	Selective catheter placement, arterial system; initial 2nd order thoracic or brachiocephalic branch, within a vascular family
36217	Selective catheter placement, arterial system; initial 3rd order or more selective thoracic or brachiocephalic branch, within a vascular family
36218	Selective catheter placement, arterial system; additional 2nd order, 3rd order, and beyond thoracic or brachiocephalic branch, within a vascular family

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath, cont'd	
36245	Selective catheter placement, arterial system; each 1st order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36246	Selective catheter placement, arterial system; initial 2nd order abdominal, pelvic, or lower extremity artery branch, within a vascular family
36247	Selective Catheter Placement, Arterial System; Initial 3rd Order or more Selective Abdominal, Pelvic, or Lower Extremity Artery Branch, within a Vascular Family
36248	Selective Catheter Placement, Arterial System; Additional 2nd Order, 3rd Order, and Beyond Abdominal, Pelvic, or lower Extremity Artery Branch, within a Vascular Family
36556	Insertion of Non-Tunneled CVC
36558	Insertion Tunneled CVC, no Port
36561	Insertion Tunneled CVC with Port
36565	Insertion Tunneled Cath w/o Port
36569	PICC Line Insertion
36571	Insertion of Peripheral CVC with Port
36575	Repair of CVC w/o Port
36576	Repair of CVC with Port

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath, cont'd	
36578	Replacement of Cath for CVC with Port
36580	Replacement of Tunneled CVC w/o Port through existing access
36581	Replacement Tunneled Catheter
36582	Replacement of complete Tunneled CVC with Port through same access
36583	Replacement of complete Non-Tunneled CVC with Port through same access
36584	Replacement of complete PICC w/o Port through same access
36585	Replacement of complete PICC w/o Port through same access
36589 36590	Removal of old CVC
36595	Mechanical Removal of Obstruction of CVC separate access
36596	Mechanical Removal of Obstruction of CVC same access
36597	Repositioning of CVC
36598	Contrast Injection for CVC
36870	AV Thrombolysis

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath, cont'd	
37184	Arterial Thrombectomy Mechanical & Pharmacological
37185	Arterial Thrombectomy Mechanical & Pharmacological additional
37186	Arterial Thrombectomy Mechanical & Pharmacological, with another procedure
37187	Venous Thrombectomy Mechanical & Pharmacological
37201	Transcatheter Therapy Non-Coronary Thrombolysis
37202	Transcatheter Therapy Non-Coronary Non-Thrombolysis
37203	Transcatheter Retrieval of Foreign Body
37205	Transcatheter Placement of an Intravascular Stent(s) except Coronary Carotid & Vertebral Vessel Percutaneous Initial Vessel
37206	Transcatheter Placement of an Intravascular Stent(s) except Coronary Carotid & Vertebral Vessel Percutaneous each additional Vessel
37207	Transcatheter Placement of an Intravascular Stent(s), (Non-Coronary /vessel), open; initial Vessel
37208	Transcatheter Placement of an Intravascular Stent(s), (Non-Coronary Vessel), open; each additional Vessel (list separate in addition to code to prim proc)

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Cardiac Cath / PTCA, cont'd

NON OPPS

Procedure Code	Description
Cardiac Cath, cont'd	
37220	Iliac Revascularization
37221	Iliac Revascularization w/Stent
37222	Iliac Revascularization add on
37223	Iliac Revascularization w/Stent add on
37224	Fem/Popliteal Revascularization w/Tia
37225	Fem/Popl Revas w/Ather
37226	Fem/Popl Revas w/Stent
37227	Fem/Popl Revasc w/Stent & Ather
37228	Tib/Per Revasc w/Tia
37229	Tib/Per Revasc w/Ather
37230	Tib/Per Revasc w/Stent
37231	Tib/Per Revasc Stent & Ather
37232	Tib/Per Revasc add-on
37233	Tib/Per Revasc w/Ather add-on
37234	Revasc Opn/Prq Tib/Pero Stent
37235	Tib/Per Revasc Stent & Ather
37607	Ligation or Banding of Angioaccess Arteriovenous Fistula

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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PTCA/ Cardiac Cath NON OPPS

Procedure Code	Description
PTCA	
92920	Prq cardiac angioplasty 1 art
92921	Prq cardiac angioplasty 1 art addl art
92924	Prq cardiac angio / arhrect 1 art
92925	Prq cardiac angio / athect addl
92928	Prq cardiac stent w/ angio 1 vsl
92929	Prq cardiac stent w/ angio addl
92933	Prq cardiac stent ath/angio
92934	Prq revasc byp graft stent ath/angio
92937	Prq revasc byp graft 1 vsl
92938	Prq revasc byp graft addl
92941	Prq cardiac revasc ml 1 vsl
92943	Prq cardiac revasc chronic 1 vsl
92944	Prq cardiac revasc chronic addl
92973	Percut coronary thrombectomy
92974	Transcatheter placement of radiation deliver device for subsequent coronary intravascular brachytherapy *(list separately in addition to code for primary procedure)*
92975 92977	Dissolve clot, heart vessel

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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PTCA / Cardiac Cath, cont'd

Procedure Code	Description
PTCA, cont'd	
92986	Revision of aortic valve
92987	Revision of mitral valve
92990	Revision of pulmonary valve
92992 92993	Revision of heart chamber
92997	Pul art balloon repair, precut
92998	Pul art balloon repair, precut
35471	Transluminal balloon angioplasty percutaneous renal or visceral artery
35472	Transluminal balloon angioplasty percutaneous aortic
35475	Transluminal balloon angioplasty percutaneous brachiocephalic trunk or branches each vessel
35476	Transluminal balloon angioplasty percutaneous venous
C9600	Perc drug-el cor stent sing
C9601	Perc drug-el cor stent bran
C9602	Perc d-e cor stent ather s
C9603	Perc d-e cor stent ather br
C9604	erc d-e cor revasc t cabg s
C9605	Perc d-e cor revasc t cabg br

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PTCA / Cardiac Cath, cont'd

Procedure Code	Description
PTCA, cont'd	
C9606	Perc d-e cor revasc w AMI s
C9607	Perc d-e cor revasc chro sing
C9608	Perc d-e cor revasc chro addn
***Note**: When revenue code 0481 (Cardiac Catheterization lab) is billed in conjunction with the revenue codes 049X, 036X, (excluding 0362 and 0367), 075X or 079X, the claim is considered to be a Cardiac Catheterization claim and would be reimbursed based on the Provider's contract*	

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Filing UB-04 Claims for Ancillary Providers and Facilities

Ambulatory Surgery Centers/ Outpatient Claims Filing

- Must file claims electronically or submit bill on UB-04 claim form.
- Must file claims electronically or bill CPT-4 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.
- Must bill standard retail rates.
- Use correct NPI in field 56.
- Modifiers are not recognized on the UB-04.
- When using the following revenue codes, the claim is considered to be an outpatient surgery admission, except if revenue code 0481 (Cardiac Cath Lab) is billed in conjunction with the following:
  - 036X – Operating Room Services *(Exclude 0362/0367)*
  - 049X – Ambulatory Surgery
  - 075X – GI Lab
  - 079X – Lithotripsy

  Note: When revenue code 0481 (Cardiac Cath Lab) is billed in conjunction with the above revenue codes, the claim is considered to be a Cardiac Cath claim and would be reimbursed based on the Provider's contract.
- If multiple services are rendered, each service must be billed on a separate line with the respective CPT or HCPCS code and a detailed charge. This does include surgical procedures. **For example:** bilateral procedures would be billed on two separate lines with the same revenue code and the respective CPT/HCPCS codes.
- 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 with a prosthetic/orthotic and/or an implant will be reimbursed based on the provider's contract.
  - 0274 – Prosthetic/Orthotic Devices
  - 0275 – Pacemaker
  - 0278 – Other Implants

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual – Filing Claims

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Filing UB-04 Claims for Ancillary Providers and Facilities, cont'd

Freestanding Cardiac Cath Lab Centers

- Must file claims electronically or bill on a UB-04 claim form.
- Modifiers are not recognized on a UB-04 claim form.
- Must itemize all services and bill standard retail rates.
- 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 Revenue Code

Cardiac Cath Lab Procedures

Procedure Code	Description
Cardiac Cath Lab Procedures	
33206	Insert heart pm atrial
33207	Insert heart pm ventricular
33208	Insert heart pm atrial & vent
33210	Insert electrd/pm cath sngl
33212	Insert pulse gen sngl lead
33213	Insert pulse gen dual leads
33214	Upgrade of pacemaker system
33215	Reposition pacing-defib lead
33216	Insert 1 elrectrode pm-defib
33221	Insert pulse gen mult leads
33223	Revise pocket for defib
33224	Insert pacing lead & connect

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Filing UB-04 Claims for Ancillary Providers and Facilities, cont'd

Cardiac Cath Lab Procedures, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
33225	L ventric pacing lead add-on
33227	Remove and replace pm gen single
33228	Remove and replace pm gen dual leads
33229	Remove and replace pm gen mult leads
33230	Insert pulse gen w/dual leads
33231	Insert pulse gen w/multi leads
33233	Removal of pm generator
33240	Insert pulse gen w/single lead
33241	Remove pulse generator
33249	Insert pace-defib w/lead
33262	Remove and replace cvd gen single lead
33263	Remove and replace cvd gen dual lead
33264	Remove and replace cvd gen mult lead
33282	Implant pat-active ht record
35311	Rechanneling of artery
35471	Repair arterial blockage
35472	Repair arterial blockage

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Filing UB-04 Claims for Ancillary Providers and Facilities, cont'd

Cardiac Cath Lab Procedures, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cond't	
35475	Repair arterial blockage
35476	Repair venous blockage
35663	Art byp illioiliac
36002	Pseudoaneurysm injection trt
36005	Injection ext venography
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36100	Establish access to artery
36120	Establish access to artery
36140	Establish access to artery
36147	Access av dial grft for eval
36148	Access av dial grft for proc
36160	Establish access to aorta
36200	Place catheter in aorta
32615	Place catheter in artery
36216	Place catheter in artery

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Cardiac Cath Lab Procedures, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
36217	Place catheter in artery
36218	Place catheter in artery
36221	Place catheter thoracic aorta
36222	Place cath carotid/inom art
36223	Place cath carotid/inom art
36224	Place cath carotid art
36225	Place cath subclavian art
36226	Place cath vertebral art
36227	Place cath subclavian art
36228	Place cath intracranial art
36245	Ins cath abd/l-ext art 1st
36246	Ins cath abd/l-ext art 2nd
36247	Ins cath abd/l-ext art 3rd
36248	Ins cath abd/l-ext art addl
36251	Ins cath ren art 1st unilat
36252	Ins cath ren art 1st bilat
36253	Ins cath ren art 2nd + unilat
36254	Ins cath ren art 2nd + bilat

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Cardiac Cath Lab Procedure, cont'c

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
36556	Insert non-tunnel cv cath
36558	Insert tunneled cv cath
36561	Insert tunneled cv cath
36569	Insert picc cath
36571	Insert picad cath
36575	Repair tunneled cv cath
36576	Repair tunneled cv cath
36578	Replace tunneled cv cath
36580	Replace cvad cath
36581	Replace tunneled cv cath
36582	Replace tunneled cv cath
36583	Replace tunneled cv cath
36584	Replace picc cath
36585	Replace4 picvad cath
36589	Removal tunneled cv cath
36590	Removal tunneled cv cath
36595	Mech remove tunneled cv cath

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Filing UB-04 Claims for Ancillary Providers and Facilities

Cardiac Cath Lab Procedures, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
36596	Mech remove tunneled cv cath
36597	Reposition venous catheter
36598	Inj w/flour eval cv device
36870	Percut thrombect av fistula
37184	Prim art mech thrombectomy
37185	Prim art m-thrombect add-on
37186	Sec art m-thrombect add-on
37187	Venous mech thrombectomy
37191	Ins endovas vena cava filter
37192	Redo endovas vena cava filter
37193	Rem endovas vena cava filter
37197	Remove intrvs foreign body
37202	Transcatheter therapy infuse
37205	Transcath iv stent precut
37206	Transcath iv stent/perc addl
37207	Transcath iv stent open
37208	Transcath iv stent/open addl

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Filing UB-04 Claims for Ancillary Providers and Facilities, cont'd

Cardiac Cath Lab Procedures, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
37211	Thrombolytic art therapy
37212	Thrombolytic venous therapy
37213	Thrombolytic art/ven therapy
37214	Cessj therapy cath removal
37220	Iliac revasc
37221	Iliac revasc w/stent
37222	Iliac revasc add-on
37223	Iliac revasc w/stent add-on
37224	Fem popl revasc w/tla
37225	Fem/popl revasc w/ather
37226	Fem/popl revasc w/stent
37227	Fem/popl revasc stent & ather
37228	Tib/per revasc w/tla
37229	Tib/per revasc w/ather
37230	Tib/per revasc w/stent
37231	Tib/per revasc stent & ather
37232	Tib/per revasc add-on

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Filing UB-04 Claims for Ancillary Providers and Facilities

Cardiac Cath Lab Procedures, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
93503	Insert/place heart catheter
93505	Biopsy of heart lining
93530	Rt heart cath congenital
93531	R&L heart cath congenital
93532	R&L heart cath congenital
93533	R&L heart cath congenital
93563	Inject congenital card cath
93565	Inject L ventr/atrial angio
93566	Inject R ventr/atrial angio
93567	Inject suprvlv aortography
93568	Inject pulm art hrt cath
0281T	Laa closure w/implant
0293T	Ins It atrl press monitor
0294T	Ins It trl mont pres lead
C9600	Perc drug-el cor stent sing
C9601	Perc drug-el cor stent bran
C9602	Perc d-e cor stent ather s

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Cardiac Cath Lab Procedures, cont'd

Filing UB-04 Claims for Ancillary Providers and Facilities, cont'd

Procedure Code	Description
Cardiac Cath Lab Procedures, cont'd	
C9603	Perc d-e cor stent ather s
C9604	Perc d-e cor revasc t cabg s
C9605	Perc d-e cor revasc t cabg br
C9606	Perc d-e cor revasc w AMI s
C9607	Perc d-e cor revasc chro sing
C9608	Perc d-e cor revasc chro addn
G0269	Occlusive device in vein art
G0275	Renal angio, cardiac cath

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Freestanding Cath Lab Centers

Procedure Code	Description
Electrophysiology Studies *(Note: Procedures must be billed using the Revenue Code 0480 with CPT procedure codes or HCPCS codes listed below)*	
93600	Bundle of His recording
93602	Intra-atrial recording
93603	Right ventricular recording
93609	Map tachycardia add-on
93610	Intra-atrial pacing
93612	Intraventricular pacing
93613	Electrophys map 3d add-on
93615	Esophageal recording
93616	Esophageal recording
93618	Heart rhythm pacing
93619	Electrophysiology evaluation
93620	Electrophysiology evaluation
93621	Electrophysiology evaluation
93622	Electrophysiology evaluation
93623	Stimulation pacing heart
93624	Electrophysiologic study

Please Note

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Freestanding Cath Lab Centers, cont'd

Procedure Code	Description
Electrophysiology Studies, cont'd *(Note: Procedures must be billed using the Revenue Code 0480 with CPT procedure codes or HC{CS codes listed below)*	
93631	Heart pacing map
93640	Evaluation heart device
93642	Electrophysiology evaluation
93650	Ablate heart dysrhythm focus
93653	Ep & ablate supravent arrhyt
93654	Ep & ablate ventric tachy
93655	Ablate arrhythmia add on
93656	Tx atrial fib pulm vein isol
93657	Tx I/r atrial fib addl
93660	Tilt table evaluation
93662	Intracardiac ecg (ice)

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Filing UB 04 Claims for Ancillary Providers and Facilities, cont's

Freestanding Cath Lab Centers, cont'd

Procedure Code	Description
Free Standing Cath Lab Other Procedures (Note: You must bill a separate claim for the below services. You cannot bill these services on the same claim as Cath Lab procedures	
71010	Chest x-ray
71034	Chest x-ray and fluoroscopy
73725	Mr ang lwr ext w or w/o dye
75600	Contrast x-ray exam or aorta
75605	Contrast x-ray exam or aorta
75625	Contrast x-ray exam or aorta
75630	X-ray aorta leg arteries
75658	Artery x-rays arm
75710	Artery x-rays arm/leg
75716	Artery x-rays arms/legs
75726	Artery x-rays abdomen
75731	Artery x-rays adrenal gland
75733	Artery x-rays adrenals
75736	Artery x-rays pelvis
75741	Artery x-rays lung
75743	Artery x-rays lungs

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Filing UB – 04 Claims for Ancillary Providers and Facilities, cont'd

Free Standing Cath Lab Other Procedures, cont'd

Procedure Code	Description
Free Standing Cath Lab Other Procedures *(Note: You must bill a separate claim for the below services. You cannot bill these services on the same claim as Cath Lab procedures)*	
75756	Artery x-ray chest
75774	Artery x-ray each vessel
75820	Vein x-ray arm/leg
75822	Vein x-ray arms/legs
75825	Vein x-ray trunk
75827	Vein x-ray chest
75831	Vein x-ray kidney
75833	Vein x-ray kidneys
75860	Vein x-ray neck
75960	Transcath iv stent rs&i
75962	Repair arterial blockage
75964	Repair artery blockage each
75966	Repair arterial blockage
75968	Repair artery blockage each
75978	Repair venous blockage

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Filing UB-04 Claims for Ancillary Providers and Facilities, cont'd

Freestanding Cath Lab Other Procedures cont'd

Procedure Code	Description
Free Standing Cath Lab Other Procedures *(Note: You must bill a separate claim for the below services. You cannot bill these services on the same claim as Cath Lab procedures)*	
76000	Fluoroscope examination
76937	US Guide vascular access
78472	Gated heart planar single
93005	Electrocardiogram tracing
93017	Cardiovascular stress test
93041	Rhythm ecg tracing

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Dialysis Claim Filing	• Must file claims electronically or bill on a UB-04 claim form. • Must bill ancillary services on same claim with treatment. • Must itemize all services and bill standard retail rates. • Must use revenue codes: • CAPD – 0841, 0845, 0849 • CCPD – 0851, 0855, 0859 • Hemodialysis – 0821, 0825, 0829 • Peritoneal – 0831, 0835, 0839 • Always include principal procedure code 39.95 for revenue codes 0821, 0841 and 0851 and principal procedure code 54.98 for revenue code 0831 in form locator 74. • Must file with your NPI number. • Per diem rates include the following charges: 1) Ancillary supplies 2) Laboratory procedures 3) Radiological procedures 4) Additional diagnostic testing 5) All nursing services 6) Utilization of in facility equipment 7) I.V. solutions 8) All pharmaceuticals *Note: The per diem is applicable only to day(s) that an actual treatment is provided.*
Freestanding Emergency Centers (FEC) 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 CPT code(s): 99281, 99282, 99283, 99284, 99285, 99291 – 99292.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Home Health Care 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.

Type of Service	Revenue Code	HCPCS Code
Skilled Nurse	055X	G0154, S9123, S9124
Physical Therapy	042X	G0151
Occupational Therapy	043X	G0152
Speech Therapy	044X	G0153
Home Health Aide	057X	G0156
Social Worker	056X	G0155
DME	0270	Refer to online fee schedule for reimbursable DME products

Please note: A G-code is equivalent to the following amount of time:

1 unit = 1 – 15 minutes

2 units = 16 – 30 minutes

3 units = 31 – 45 minutes

4 units = 46 – 60 minutes

- Services must be ordered by a physician and require a physician singed treatment plan.
- 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.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Home Health Care Claim Filing, cont'd

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

- Initial phases of regimen involving administration of medical gases.
- Intravenous or intramuscular injections and intravenous feeding except as indicted 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 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.

Non-Skilled Service Examples for Home Health Care

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 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 in connection with indwelling bladder catheters, including emptying and cleaning containers, clamping tubing, and refilling irrigation containers with solution.
- Administration of medical gases and respiratory therapy after 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 in connection 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.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Non-Skilled Service Examples for Home Health Care, cont'd	• General supervision of exercises that have been taught to the patient or range of motion exercises designed for strengthening or to prevent contractures. • Tube feeding on a continuing basis after care has been instituted and taught. • Assistance in dressing, eating, and going to the toilet.
Hospice Claim Filing	• Must file claims electronically or bill on a UB-04 claim form. • Must use appropriate revenue codes for services rendered. When billing revenue codes, use: • 0651 – Routine Home Hospice (Intermittent) • 0652 – Continuous Home Hospice • 0655 – Inpatient Respite Care • 0656 – Inpatient Hospice Services • Must preauthorize 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 precertification number from the HMO. • All non-routine items must be supplied by the appropriate provider specialty. For example: A special hospital bed or customized wheelchair must be supplied and billed by a Durable Medical Equipment (DME) provider.
Radiation Therapy Center Claim Filing	• Must file claims electronically or bill on a UB-04 claim form if facility is Hospital Based, or CMS-1500 (02/12) – if facility is freestanding. • Must bill negotiated rates according to fees stated in contract. • Must use the appropriate revenue codes and the corresponding CPT/HCPCS codes. • When the member's coverage requires a PCP referral, form locator 63 must be completed with a referral authorization number obtained from the HMO.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Skilled Nursing Facility Claim Filing	• Must file claims electronically or bill on a UB-04 claim form. • Must use appropriate revenue codes for services rendered *(refer to UB-04 manual)* • Must itemize all services and bill standard retail prices. • Must use NPI in field 56. • Must preauthorize before services are rendered. • Must initiate preauthorization no later than the 21st day of confinement when Medicare A is primary for patients with HMO secondary coverage. • Must use 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. • Must complete form locator 63 with a referral authorization number if HMO Group and preauthorization number obtained from HMO. • 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.
Rehab Hospital Claim Filing	• Must file claims electronically or bill on a UB-04 claim form. • Must use appropriate room revenue code ending in 8. For example: Private rehab room 0118 and semiprivate room 0128. • Must precertify before services are rendered. • Must complete form locator 63 with a referral authorization number if HMO Group and/or a precertification number obtained from the HMO.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Blue Essentials Only Submit Encounter Data Electronically	The primary difference between a Blue Cross and Blue Shield of Texas claim and an **Blue Essentials** claim is the length of the patient's member ID number. The **Blue Essentials** member ID number is an 11-digit number. This number should be taken directly from the patient's ID card. The last two digits of the member ID number indicate the number assigned to each enrolled dependent under the member. The values for the last two digits range from 00 to 99. To ensure accurate processing, claims received electronically should include the full 11-digit member number.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Claim Review Process

Blue Essentials, Blue Advantage HMO and Blue Premier have two claim review levels available to physicians, professional providers, facility and ancillary providers.

Claim review requests must be submitted in writing on the **"Claim Review Form"** form located later in this manual. Also, this form may be found on the BCBSTX website at bcbstx.com/provider under the Educational & Reference Center tab.

At the time the claim review request is submitted, please attach any additional information you wish to be considered in the claim review process. This information may include:

- Reason for claim review request
- Progress notes
- Operative report
- Diagnostic test results
- History and physical exam
- Discharge summary
- Proof of timely filing

Note: If you are submitting additional information due to receiving a letter from BCBSTX requesting it, it should be submitted using the letter received or the **Additional Information Form.** If you need to submit a corrected claim, you should submit it electronically or if you must submit paper, it should include a **Corrected Claim Form.** These forms can be found under Forms under the Education and Reference section on the **bcbstx.com/provider** website.

Proof of Timely Filing

For those claims which are being reviewed for timely filing, **Blue Essentials, Blue Advantage HMO and Blue Premier** will accept the following documentation as acceptable proof of timely filing:

- TDI Mail Log
- Certified Mail Receipt (only if accompanied by TDI mail log)
- Availity Electronic Batch (EBR) Response Reports
- Above documentation indicating that the claim was filed with the wrong division of Blue Cross and Blue Shield of Texas
- Documentation from **Blue Essentials, Blue Advantage HMO or Blue Premier** indicating claim was incomplete
- Documentation from **Blue Essentials, Blue Advantage HMO or Blue Premier** requesting additional information
- Primary carrier's EOB indicating claim was filed with primary carrier within the timely filing deadline.

Mail the "Claim Review" form, along with any attachments, to the appropriate address indicated on the form.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

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Claims Reviews, Dispute Types & Timeframe for Requests

There are two (2) levels of claim reviews available to you. For the following circumstances, the 1st claim review must be requested within the corresponding timeframes outlined below:

DISPUTE TYPE	TIMEFRAME FOR REQUEST
Audited Payment	Within **45** days following the receipt of written notice of request for refund due to audited payment
Overpayment	Within **45** days following the receipt of written notice of request for refund due to overpayment
Claim Dispute	Within **180** days following the check date/date of the **Blue Essentials. Blue Advantage HMO or Blue Premier** Explanation of Payment (EOP), or the date of the BCBSTX Provider Claims summary (PCS), for the claim in dispute

Blue Essentials, Blue Advantage HMO or Blue Premier will complete the 1st claim review within **45** days following the receipt of your request for a 1st claim review.

- You will receive a written notification of the claim review determination

If the claim review determination is not satisfactory to you, you may request a 2nd claim review. The 2nd claim review must be requested within **15** days following your receipt of the 1st claim review determination.

- **Blue Essentials, Blue Advantage HMO or Blue Premier** will complete the 2nd claim review within **30** days following the receipt of your request for a 2nd claim review.
- You will receive written notification of the claim review determination.
- The claim review process for a specific claim will be considered complete following your receipt of the 2nd claim review determination.

Claim Review Form

This form is only to be used for review of a previously adjudicated claim. Original Claims should not be attached to a review form. Do not use this form to submit a Corrected Claim or to respond to an Additional Information request from BCBSTX. Submit only one form per patient.

*****Inquiries received without the required information below may not be reviewed.*****

Claim Number: **(For multiple claims provide the additional claim number below)**		
Group Number:	Prefix (3 character alpha):	Member Identification Number:
Patient Name: (Last, First)		
Date(s) of Service:		Total Billed Amount:
Provider Name:		NPI:
Contact Person:		Phone Number:
Provide detailed information about your review request, including additional claim numbers, if applicable. Attach supporting documentation, if necessary.		

REMINDERS

- **Mail inquiries to:** Blue Cross and Blue Shield of Texas
  P.O. Box 660044
  Dallas, TX 75266-0044
- **Additional Information requests** – If you received an Additional Information request from BCBSTX, follow the instructions provided and use that letter as the cover sheet. If you do not have the cover sheet please use the Additional Information Form located at bcbstx.com/provider. *Examples of additional information include, but aren't limited to: Medical Records, Operative Reports, Coordination of Benefits, Medicare Explanation of Benefits, etc.*
- **Corrected Claim requests** should be submitted as electronic replacement claims, or on a paper claim form along with a Corrected Claim Review Form available on our website at bcbstx.com/provider.

To submit Claim Review requests online utilize the Claim Inquiry Resolution tool, accessible through Electronic Refund Management (ERM) on the Availity™ Web Portal at *availity.com*.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Recoupment Process

Recoupment Process Blue Essentials, Blue Advantage HMO or Blue Premier
The Refund Policy for **Blue Essentials, Blue Advantage HMO or Blue Premier** states that **Blue Essentials, Blue Advantage HMO or Blue Premier** has 180 days following the payee's receipt of an overpayment to notify a physician, professional provider, facility or ancillary provider that the overpayment has been identified and to request a refund.* For additional information on the Blue Essentials, Blue Advantage HMO or Blue Premier Refund Policy, including when a physician, professional provider, facility or ancillary provider may submit a claim review and when an overpayment may be placed into recoupment status, please refer to the **"Refund Policy – Blue Essentials, Blue Advantage HMO or Blue Premier"** on further on in Section F in the Blue Essentials, Blue Advantage HMO and Blue Premier Physician, Professional Provider, Facility and Ancillary Provider – Provider Manual. In some unique circumstances a physician, professional provider, facility or ancillary provider may request, in writing, that **Blue Essentials, Blue Advantage HMO and Blue Premier** review all claims processed during a specified period; in this instance all underpayments and overpayments will be addressed on a claim-by- claim basis. *Note - The refund request letter may be sent at a later date when the claim relates to Blue Essentials, Blue Advantage HMO or Blue Premier accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including: • Self Funded ERISA (Employee Retirement Income Security Act • Indemnity Plans • Medicaid, Medicare and Medicare Supplement • Federal Employees Health Benefit Plan • Self – funded governmental, school and church health plans • Out – of – State Blue Cross and Blue Shield plans (Blue Card) • Out – of – Network (non – participating) providers • Out – of – state provider claims including Away from Home Care

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual – Filing Claims

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Recoupment Process, cont'

Recoupment Process
Blue Essentials, Blue Advantage HMO or Blue Premier , cont'd

When a physician's, professional provider's, facility or ancillary provider's overpayment is placed into a recoupment status, the claims system will automatically off-set future claims payment and generate a Provider Claims Summary (PCS) to the physician, professional provider, facility provider or ancillary provider. (Recoupment Process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable ***Blue Essentials , Blue Advantage HMO or Blue Premier*** *claim(s).*

To view an example of a recoupment, please refer to the sample PCS below in Section F in the ***Blue Essentials, Blue Advantage HMO and Blue Premier*** *Physician, Professional Provider, Facility and Ancillary Provider – Provider Manual.*

For additional information or if you have questions regarding the Recoupment Process, please contact **877-299-2377** to speak with an **Blue Essentials** Customer Advocate or contact **800-451-0287** to speak with a **Blue Advantage HMO** Customer Advocate or contact **800-876-2583** to speak with a **Blue Premier** Customer Advocate.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Sample PCS Recoupment

DATE: MM/DD/YY
PROVIDER NUMBER: 0001112222
CHECK NUMBER: 123456789
TAX IDENTIFICATION NUMBER: 987654321

1 2 3 4

5 ABC MEDICAL GROUP
123 MAIN STREET
ANYTOWN, TX 70000

ANY MESSAGES WILL APPEAR ON PAGE 1

6 PATIENT: JOHN DOE
7 PERF PRV: 1234567890
8 CLAIM NO: 00001234567890C

9 IDENTIFICATION NO: P06666-XOC123456789
10 PATIENT NO: 12345KB

11 FROM/TO DATES	12 PS*	13 PAY	14 PROC CODE	15 AMOUNT BILLED	16 ALLOWABLE AMOUNT	17 SERVICES NOT COVERED	18 DEDUCTIONS/ OTHER INELIGIBLE	19 AMOUNT PAID
02/09 – 02/09/12	03	HMO	99213	76.00	50.52	(1) 25.48	0.00	50.52
				76.00	50.52	25.48	0.00	50.52

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $50.52

DEDUCTIONS/OTHER INELIGIBLE

21 TOTAL SERVICES NOT COVERED: 25.48
22 PATIENT'S SHARE: 0.00

23 PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS:	1	AMOUNT PAID TO SUBSCRIBER:	$0.00
AMOUNT BILLED:	$76.00	AMOUNT PAID TO PROVIDER:	$50.52
AMOUNT OVER MAXIMUM ALLOWANCE:	$25.48	RECOUPMENT AMOUNT:	$31.52
AMOUNT OF SERVICES NOT COVERED:	$25.48	NET AMOUNT PAID TO PROVIDER:	$19.00
AMOUNT PREVIOUSLY PAID:	$0.00		

24

* PLACE OF SERVICE (PS)
03 PHYSICIAN'S OFFICE.

25 MESSAGES:
(1).CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICE PROVIDED BY A PARTICIPATING PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Professional Provider Claim Summary Field Explanations:

1	**Date**	Date the summary was finalized
2	**Provider Number**	Provider's NPI
3	**Check Number**	The number assigned to the check for this summary
4	**Tax Identification Number**	The number that identifies your taxable income
5	**Provider or Group Name and Address**	Address of the provider/group who rendered the services
6	**Patient**	The name of the individual who received the service
7	**Performing Provider**	The number that identifies the provider that performed the services
8	**Claim Number**	The Blue Shield number assigned to the claim
9	**Identification Number**	The number that identifies the group and member insured by BCBSTX
10	**Patient Number**	The patient's account number assigned by the provider
11	**From / To Dates**	The beginning and ending dates of services
12	**PS**	Place of service
13	**PAY**	Reimbursement payment rate that was applied in relationship to the member's policy type
14	**Procedure Code**	The code that identifies the procedure performed
15	**Amount Billed**	The amount billed for each procedure/service
16	**Allowable Amount**	The highest amount BCBSNM will pay for a specific type of medical procedure.
17	**Services Not Covered**	Non-covered services according to the member's contract
18	**Deductions / Other Ineligible**	Program deductions, copayments, and coinsurance amounts
19	**Amount Paid**	The amount paid for each procedure/service
20	**Amount Paid to Provider for This Claim**	The amount Blue Shield paid to provider for this claim
21	**Total Services Not Covered**	Total amount of non-covered services for the claim
22	**Patient's Share**	Amount patient pays. Providers may bill this amount to the patient.
23	**Provider Claims Amount Summary**	How all of the claims on the PCS were adjudicated
24	**Place of Service (PS)**	The description for the place of service code used in field 12
25	**Messages**	The description for messages relating to: non-covered services, program deductions, and HMO reductions

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Refund Policy

Refund Policy
Blue Essentials, Blue Advantage HMO or Blue Premier

Blue Essentials, Blue Advantage HMO and **Blue Premier** strive to pay claims accurately the first time; however, when payment errors occur, **Blue Essentials, Blue Advantage HMO and Blue Premier** needs your cooperation in correcting the error and recovering any overpayment.

When a Physician, Professional Provider, Facility or Ancillary Provider identifies an overpayment:

- If you identify a refund due to **Blue Essentials, Blue Advantage HMO or Blue Premier**, please submit your refund to the following address:

  Blue Cross and Blue Shield of Texas
  P.O. Box 731431
  Dallas, TX 75373-1431

- View Provider Refund Form

When Blue Essentials, Blue Advantage HMO or Blue Premier Identifies an Overpayment:

If **Blue Essentials, Blue Advantage HMO or Blue Premier** identifies an overpayment, a refund request letter will be sent to the payee within 180 days following the payee's receipt of the overpayment that explains the reason for the refund and includes a remittance form and a postage-paid return envelope. In the event that **Blue Essentials, Blue Advantage HMO or Blue Premier** does not receive a response to their initial request, a follow-up letter is sent requesting the refund.

- Within 45 days following its receipt of the initial refund request letter *(Overpayment Review Deadline)*, the physician, professional provider, facility or ancillary provider may request a claim review of the overpayment determination by **Blue Essentials, Blue Advantage HMO or Blue Premier** by submitting a Claim Review form in accordance with the Claim Review Process referred to below. In determining whether this deadline has been met, **Blue Essentials, Blue Advantage HMO or Blue Premier** will presume that the refund request letter was received on the 5th business day following the date of the letter.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Refund Policy, cont'd

Refund Policy
Blue Essentials, Blue Advantage HMO or Blue Premier, cont'd

- Within 45 days following its receipt of the initial refund request letter *(Overpayment Review Deadline)*, the physician, professional provider, facility or ancillary provider may request a claim review of the overpayment determination by **Blue Essentials , Blue Advantage HMO or Blue Premier** by submitting a Claim Review form in accordance with the Claim Review Process referred to below. In determining whether this deadline has been met, **Blue Essentials, Blue Advantage HMO or Blue Premier** will presume that the refund request letter was received on the 5th business day following the date of the letter.
- If **Blue Essentials, Blue Advantage HMO or Blue Premier** does not receive payment in full within the Overpayment Review Deadline, they will recover the overpayment by offsetting current claims reimbursement by the amount due **Blue Essentials, Blue Advantage HMO or Blue Premier** *(refer to Recoupment Process on further on in this provider manual)* after the later of the expiration of the Overpayment Review Deadline or the completion of the Claim Review Process provided that the physician, professional provider, facility or ancillary provider has submitted the Claim Review form within the Overpayment Review Deadline.
- For information concerning the Recoupment Process, please refer to the "Recoupment Process – **Blue Essentials, Blue Advantage HMO and Blue Premier** in the Blue Essentials, Blue Advantage HMO and Blue Premier Physician, Professional Provider, Facility and Ancillary Provider – Provider Manual.

Note: *In some unique circumstances a physician, professional provider, facility or ancillary provider may request, in writing, that* ***Blue Essentials, Blue Advantage HMO or Blue Premier*** *review all claims processed during a specified period; in this instance all underpayments* and overpayments will be addressed on a claim-by- claim basis.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.

Refund Policy,cont'd

Refund Policy
Blue Essentials, Blue Advantage HMO or Blue Premier, cont'd

For additional information or if you have questions regarding the Refund Policy, please contact **877-299-2377** to speak with an **Blue Essentials** Customer Advocate or contact **800-451-0287** to speak with a **Blue Advantage HMO** Customer Advocate or **800-876-2583** to speak with a **Blue Premier** Customer Advocate.

If you want to request a review of the overpayment decision, please view the Claim Review Process along with the Claim Review Form & Instructions within this Section F in the Blue Essentials, Blue Advantage HMO and Blue Premier Physician, Professional Provider, Facility and Ancillary Provider – Provider Manual. You can also locate the Claim Review Form and Instructions on the BCBSTX Provider website at bcbstx.com/provider. The information is located under the Education & Reference Center tab/Forms section.

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

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Refund Letters – Identifying Reason for Refund

Blue Essentials, Blue Advantage HMO and Blue Premier refund request letters include information about the specific reason for the refund request, as follows:

- The services rendered require *Preauthorization/Referral*; none was obtained.
- Your claim was processed with an *incorrect copay/coinsurance or deductible.*
- Your claim was received after the timely filing period; *proof of timely filing needed.*
- Your claim was processed with the *incorrect fee schedule/allowed amount.*
- Your claim should be submitted to the *member's IPA or Medical Group.*
- Your claim was processed with the *incorrect anesthesia time/minutes.*
- Your claim was processed with in-network benefits; however, it should have been processed with *out-of-network benefits.*
- Total charges processed exceeded the amount billed.
- Per the Member/Provider this claim was submitted in error.
- *Medicare should be primary* due to ESRD. Please file with Medicare and forward the EOMB to BlueCross and BlueShield.
- The patient has *exceeded the age limit* and is not eligible for services rendered.
- The patient listed on this claim is *not covered under the referenced policy.*
- The dependent was *not a full time student* when services were rendered; benefits are not available.
- The claim was processed with *incorrect membership information.*
- The services were performed by the anesthesiologist; however, they were *paid at the surgeon's benefit level.*
- The services were performed by the assistant surgeon; however, they were *paid at the surgeon's benefit level.*
- The services were performed by the co-surgeon; however, they were *paid at the surgeon's benefit level.*
- The service rendered was considered a *bilateral procedure*; separate procedure not allowed.
- Claims submitted for rental; *DME has exceeded purchase price.*
- Overpayment was identified as another insurance carrier is the primary for this patient. HCSC is the secondary carrier, but paid primary in error.

* **Note:** The refund request letter may be sent at a later date when the claim relates to **Blue Essentials and Blue Advantage HMO** accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:

- Self-funded ERISA (Employee Retirement Income Security Act)
- Indemnity Plans
- Medicaid, Medicare and Medicare Supplement
- Federal Employees Health Benefit Plan
- Self-funded governmental, school and church health plans
- Out-of-state Blue Cross and Blue Shield plans (BlueCard)
- Out-of-network (non-participating) providers

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Provider Refund Form (Sample)

Please submit refunds to: Blue Cross and Blue Shield of Texas, PO Box 731431, Dallas, TX 75373-1431

Provider Information:			
Name:			
Address:			
Contact name:			
Phone Number:			
NPI Number:			

	Refund Information			
1	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			
	Refund Information			
2	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			
	Refund Information			
3	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			
	Refund Information			
4	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			
	Refund Information			
5	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			

SIGNATURE	DATE	CHECK NUMBER	CHECK DATE

Blue Essentials Blue Advantage HMO and Blue Premier Provider Manual Filing Claims

Provider Refund Form Instructions

Refunds Due to Blue Cross and Blue Shield of Texas

1. Key Points to check when completing this form:

a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) – including group and member's identification number

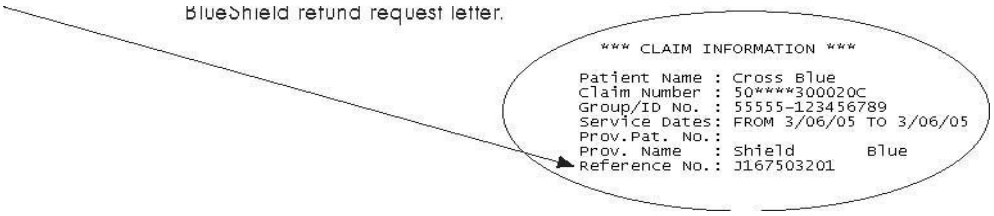
b) Admission Date: Indicate the admission or outpatient service date as MMDDYY entry.

c) BCBS Claim/DCN #: Indicate the BlueCross BlueShield Claim/DCN number as it appears on the PCS/EOB.

Please do not use your provider patient number in this field.

d) Provider Patient #: Indicate the Patient account number assigned by your office.

e) Letter Reference #: **If applicable**, indicate the RFCR letter reference number located in the BlueCross BlueShield refund request letter.



f) Check Number and Date: Indicate the check number and date you are remitting for this refund.

g) Amount: Enter the total amount refunded to BlueCross Blue Shield.

h) Remarks/Reason: Indicate the reason as follows:

- "C.O.B. Credit" — Payment has been received under two different Blue Cross memberships or from Blue Cross and another carrier. Indicate name, address, and amount paid by other carrier.
- "Overpayment" — Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract.
- "Duplicate Payment" — A duplicate payment has been received from BlueCross for one instance of service (e.g. same group and member number).
- "Not our Patient" — Payment has been received for a patient that did not receive services at this facility/treatment center.
- "Medicare Eligible Duplicate Payment" — Payment for the same service has been received from Blue Cross and the Medicare intermediary.
- "Workers Compensation" — Payment for the same service has been received from Blue Cross and a Workers' Compensation carrier.

2. Mail the refund form along with your check to:

Blue Cross and Blue Shield of Texas
PO Box 731431
Dallas, TX 75373-1431

Blue Essentials, Blue Advantage HMO and Blue Premier Provider Manual - Filing Claims

Please Note	Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO and Blue Premier**. These product specific requirements will be noted with the product name.
Electronic Refund Management (ERM)	This on-line refund management tool will help simplify overpayment reconciliation and related processes. The eRM application is available at **no additional charge**. Enjoy **single sign-on** through Availity® *(Note: You must be a registered user with Availity to take advantage of eRM.)* **To register:** • **Visit the** Availity website at availity.com • Receive **electronic notifications of overpayments** to help reduce record maintenance costs. • **View overpayment requests** – search/filter by type of request, get more details and obtain real-time transaction history for each request. • **Settle your overpayment requests** – Have BCBSTX deduct the dollars from a future claim payment. Details will appear on your PCS or EPS; information in your eRM transaction history can also assist with recoupment reconciliations. • **Pay by check** – You will use eRM to generate a remittance form showing your refund details. One or multiple requests may be refunded to BCBSTX check number(s) will show on-line. • **Submit unsolicited refunds** – If you identify a credit balance, you can elect to submit it on-line and refund your payment to BCBS by check, or have the refund deducted from a future claim payment. • Stay aware with system **Alerts** – You will receive notification in certain situations, such as if BCBSTX has responded to your inquiry or if a claim check has been stopped.
How to Gain Access to eRM Availity Users	Click on the *HCSC Refund Management* link under the "Claims Management" tab. If you are unable to access this link, please contact your Primary Access Administrator (PAA). If you do not know who your Primary Access Administrator is, click on *Who controls my access?* You may also contact Availity Client Services at **800-AVAILITY (282-4548)** for assistance, or visit the Availity website for more information.