BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual - Filing Claims - Ancillary Services

Please Note

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

The following topics are covered in this section:

In this Section

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Ancillary Services

It is important that providers submit ancillary claims accurately and completely. To assist, Blue Cross and Blue Shield of Texas (BCBSTX) has provided the following information and guidelines. In addition, refer to the Clinical Payment and Coding Policies on the provider website for specific information.

Capitated Medical Group - Important Note

Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting, and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated

Medical Group are subject to that entity's procedures and requirements for the Plan's provider complaint resolution.

Prior Authorizations and Recommended Clinical Review

It is important that providers submit ancillary claims accurately and completely. To assist, BCBSTX has provided the following information and guidelines. In addition, refer to the **Clinical Payment and Coding Policies** on the provider website for specific information.

Either BCBSTX Medical Management or Carelon Medical Benefits Management (Carelon) may be responsible for prior authorization for certain ancillary services.

Providers should refer to Utilization Management or the Carelon pages on the BCBSTX provider website and check eligibility and benefits through Availity® or their preferred vendor to determine prior authorization requirements and who to contact.

Recommended Clinical Review (RCR) is recommended for medical necessity to determine benefit coverage when there is no prior authorization requirement for the service. Refer to the Recommended Clinical Review page on the provider website for more information. Providers can submit Recommended Clinical Review requests electronically through the Availity Attachments Tool or fax completed Recommended Clinical Review Forms to 1-888-579-7935. RCR is not applicable to services managed by Carelon.

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Prior Authorizations and Recommended Clinical Review

Services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member. For more information, on prior authorizations refer to sections C & E of this provider manual.

Prior authorization 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:
  - Cosmetic procedures
  - Failure to call on a timely basis (Prior to delivery of services
  - Limitations contained in riders, if any

Diabetic Education

Diabetic Education Center

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

- Use **CMS-1500** claim form
- Use POS "99" for the place of service
- Use diabetes as the primary (International Classification of Diseases (ICD-10) diagnosis
- Use appropriate procedure codes for services rendered
- File with your National Provider Identifier (NPI) number

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Durable Medical Equipment (DME)

The **Plans** describe 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 i n 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 DME when the equipment is prescribed by a physician within the scope of his license or a Physician Assistant or Advance Practice Nurse (with counter signature by their supervising physician) 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" 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:

- Equ… patient,
- Is M…
- The… ible.

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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 Prior Authorization

Prior authorization 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

Check eligibility and benefits through Availity® or your preferred vendor to determine prior authorization or if the member's plan has specific prior authorization rules based on DME cost.

Recommended Clinical Review (formerly predeterminations) is recommended for medical necessity determination to determine benefit coverage. Providers can fax completed Recommended Clinical Review Forms to **1-888-579-7935** for urgent requests.

Note: Failure to prior authorize, may result in non-payment and providers cannot collect these fees from **Plan** members. Prior authorization 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 DME)*
  - Limitations contained in riders, if any

DME Prior Authorization, cont.

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

- Prior authorization may be obtained by calling:

  Blue Essentials: 1-800-441-9188
  Blue Advantage HMO: 1-855-462-1785
  Blue Premier: 1-800-441-9188
  MyBlue Health: 1-855-462-1785

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 and 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 Blue Cross and Blue Shield of Texas (BCBSTX) that has been processed and paid.

Prescription or Certificate of Medical Necessity, cont.

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.

Life Sustaining DME List

HCPCS* Code	Description BCBSTX Life Sustaining DME
E0424	Stationary compressed gas 02
E0431	Portable gaseous O2 and tubing
E0433	Portable liquid oxygen sys
E0434	Portable liquid O2
E0439	Stationary liquid O2
E0441	Stationary O2 contents, gas
E0442	Stationary O2 contents, liq
E0443	Portable 02 contents, gas
E0444	Portable 02 contents, liquid
E0465	Home vent invasive interface
E0466	Home vent non-invasive inter

*HCPCS -Healthcare Common Procedure Coding System

Life Sustaining DME List, cont.

HCPCS Code	Description BCBSTX Life Sustaining DME
E0481	Intrpulmnry percuss vent sys
E0618	Apnea monitor
E0619	Apnea monitor w/ recording feature
E1390	Oxygen concentrator
E1391	Oxygen concentrator, dual
E1392	Portable oxygen concentrator
E1590	Hemodialysis machine
E1592	Auto interm peritoneal dialy
E1594	Cycler dialysis machine
K0738	Portable gas oxygen system
S8120	O2 contents gas cubic ft
S8121	O2 contents liquid lb

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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.
- Reference the **Home Infusion Clinical Payment and Coding Policy**
- 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.
- Providers should refer to"Factor Products" as identified in the Home Infusion Therapy Drug Schedule posted on the BCBSTX provider website . The codes are subject to change in accordance with the terms of the agreement.
- **Nursing Visits**: For nursing visits, prior authorize Current Procedural Terminology (CPT®) codes 99601 and 99602. For extended visits, prior authorize CPT code 99602.
- Always bill using a valid procedure code (CPT, HCPCS and National Drug Code (NDC) 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 procedure code defines the drug as 1 gram and you administered 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 procedure code for the administered drug, in which case you would then bill using J-3490 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 prior authorized if the HIT services are not defined in an established per diem code.

The per diem for aerosolized drug therapy (S9061) does not include the cost of the nebulizer. The nebulizer must be purchased or rented through an 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

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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	

Home Infusion Therapy Schedule

Codes and pricing are listed on the BCBSTX website under **Standards and Requirements** then **General Reimbursement Information**. Providers must verify codes and pricing prior to rendering services.

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Filing CMS-1500 Claims for Ancillary Facilities

Imaging Centers

File claims electronically with BCBSTX or submits **CMS-1500**

- Must use CPT-4 coding structure
- Use POS "49" as the 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

Imaging Procedures Prior Authorization or Prenotification

BCBSTX is contracted with the Carelon Medical Benefits Management (Carelon) formerly AIM Specialty Health® for certain radiology services:

Carelon may require prior authorization and post service medical necessity review for certain outpatient advanced imaging and cardiology related imaging services or a prenotification Radiology Quality Initiative (RQI) for certain outpatient high-tech diagnostic imaging services.

For details on specific services including specific procedure codes that require prior authorization or prenotification for the RQI program, refer to the Carelon and Utilization Management pages on the BCBSTX provider website.

When prior authorization or prenotification RQI's are needed through Carelon, ordering physicians for **Plan** patients must contact Carelon to obtain a prior authorization or an RQI order request number.

Ordering physicians must write the order request number on the requisition for the imaging study. The ordering physician/professional provider is required to contact Carelon, whether the ordering provider is the PCP or the specialist. The PCP will not be expected to obtain the order request number if a specialist orders the test. **The order request number must be on the performing provider's claim form UB-04 or CMS-1500s.**

When the ordering physician/professional provider submits the order through the Carelon ProviderPortal, they will experience suggestions to include imaging sites that have an "A" score. Please note: The ordering provider will still be able to search for additional servicing providers in your network.

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Imaging Center Tests Not Typically Covered

The following tests are not typically covered. Be sure to check eligibility and benefits and prior authorization through Availity or your preferred vendor to check member's coverage.

70371 – Speech evaluation complex

76000 – Fluoroscopy, 1 hr phys/qhp

76140 – X-ray consultation

76511 – Ophth US quant only

76512 – Ophth US w/non quant A

76513 – Echo exam of eye waterbath

76516 – Echo exam of eye

76519 – Echo exam of eye

76529 – Echo exam of eye

77058–77079 – MRI of the breast

78469 – IO radiation TX management

PET Scans

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Independent Laboratory Claims Filing	• File claims electronically with BCBSTX or submit **CMS-1500** • 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 Providers	**Plan** providers should refer members to in-network lab providers for outpatient lab services. To locate participating labs in the Blue Choice PPO network, visit the online Provider Directory on the BCBSTX website.
Prior Authorization for Certain Outpatient Lab Services	BCBSTX is contracted with Carelon to manage prior authorization services for certain lab services. Refer to the Carelon page for information on specific services requiring prior authorization as well as how to prior authorize services.

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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
    - Capillary 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 vereream
    - 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)*

Independent Laboratory – Non-Covered Tests

- Appolipoprotein immunoassay testing
- Automated hemogram
- Candida enzyme immunoassay (CEIA)
- Captopril challenge test
- Cervigram (cervicography)
- 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
- 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

Providers should check eligibility and benefits through Availity® or their preferred vendor.

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Prosthetics/ Orthotics

- File claims electronically with BCBSTX or submit CMS-1500
- 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

Prosthetics & Orthotics Non Covered

Prosthetics & Orthotics not typically covered may include but are not limited to:

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, immobilize slings
L3000	Ft insert ucb berkeley shell
L3001	Foot insert remov molded spe
L3002	Foot insert plastazote or eq
L3003	Foot insert silicone gel eac
L3010	Foot longitudinal arch suppo
L3030	Foot arch support remov prem
L3040	Ft arch suprt premold longit
L3050	Foot arch supp premold metat
L3060	Foot arch supp longitud/meta
L3070	Arch suprt att to sho longit
L3080	Arch supp att to shoe metata
L3090	Arch supp att to shoe long/m

Prosthetics & Orthotics – Non- Covered, cont.

HCPCS Code	Description
L3100	Hallus-valgus nt dyn pre ots
L3170	Foot plas heel stabi pre ots
L3201	Oxford w supinat/pronat inf
L3202	Oxford w/ supinat/pronator c
L3203	Oxford w/ supinator/pronator
L3204	Hightop w/ supp/pronator inf
L3206	Hightop w/ supp/pronator chi
L3207	Hightop w/ supp/pronator jun
L3215	Orthopedic ftwear ladies oxf
L3216	Orthoped ladies shoes dpth i
L3217	Ladies shoes hightop depth i
L3219	Orthopedic mens shoes oxford
L3221	Orthopedic mens shoes dpth i
L3222	Mens shoes hightop depth inl
L3230	Custom shoes depth inlay
L3250	Custom mold shoe remov prost

Prosthetics & Orthotics – Non-Covered, cont.

HCPCS Code	Description
L3251	Shoe molded to pt silicone s
L3252	Shoe molded plastazote cust
L3253	Shoe molded plastazote cust
L3254	Orth foot non-stndard size/w
L3255	Orth foot non-standard size/
L3260	Ambulatory surgical boot eac
L3265	Plastazote sandal each
L3300	Sho lift taper to metatarsal
L3310	Shoe lift elev heel/sole neo
L3320	Shoe lift elev heel/sole cor
L3330	Lifts elevation metal extens
L3332	Shoe lifts tapered to one-ha
L3334	Shoe lifts elevation heel /i
L3340	Shoe wedge sock
L3350	Shoe heel wedge
L3360	Shoe sole wedge outside sole
L3370	Shoe sole wedge between sole
L3380	Shoe clubfoot wedge
L3390	Shoe outflare wedge

Prosthetics & Orthotics – Non-Covered, cont.

HCPCS Code	Description
L3430	Sho heel count plast reinfor
L3440	Heel leather reinforced
L3450	Shoe heel sach cushion type
L3455	Shoe heel new leather standa
L3460	Shoe heel new rubber standar
L3465	Shoe heel thomas with wedge
L3470	Shoe heel thomas extend to b
L3480	Shoe heel pad & depress for
L3485	Shoe heel pad removable for
L3500	Ortho shoe add leather insol
L3510	Orthopedic shoe add rub insl
L3520	O shoe add felt w leath insl
L3530	Ortho shoe add half sole
L3540	Ortho shoe add full sole
L3550	O shoe add standard toe tap
L3560	O shoe add horseshoe toe tap
L3649	Orthopedic shoe modifica NOS
A6530	Compression stocking BK18-30

Prosthetics & Orthotics – Non-Covered, cont.

HCPCS Code	Description
A6531	Compression stocking BK30-40
A6532	Compression stocking BK40-50
A6533	Gc stocking thighlngth 18-30
A6534	Gc stocking thighlngth 30-40
A6535	Gc stocking thighlngth 40-50
A6536	Gc stocking full lngth 18-30
A6537	Gc stocking full lngth 30-40
A6538	Gc stocking full lngth 40-50
A6539	Gc stocking waistlngth 18-30
A6540	Gc stocking waistlngth 30-40
A6541	Gc stocking waistlngth 40-50
A6544	Gc stocking garter belt
S9999	Sales tax

Providers should check eligibility and benefits through Availity® or their preferred vendor.

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Radiation Therapy Center Claim Filing

- Must use appropriate CMS claim form or electronic equivalent **Note:** Use UB-04 or electronic equivalent, if a facility;or Use CMS-1500 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 Primary Care Provider referral, form locator 63 must be completed with a referral authorization number obtained from BCBSTX.
- Must file with your NPI number