BlueCross BlueShield of Texas

Preventive Medicine Billing Guidelines

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- The CPT code set was designated by the Department of Health and Human Services as the national coding standard for physician and other health care professional services and procedures under the Health Insurance Portability and Accountability Act (HIPAA). This means that the CPT code set must be used for all financial and administrative health care transactions sent electronically.
- Blue Cross and Blue Shield of Texas (BCBSTX) requires practitioners to use CPT codes when submitting claims for services provided to members. If there is no CPT code that identifies the services performed, a practitioner may report those services with a HCPCS code, if available. Otherwise, the appropriate CPT "unlisted" code may be submitted with a complete description of services provided.
- Clear Claim Connection™ (CCC), a web-based code auditing reference tool, is available to all contracted Blue Cross Blue Shield of Texas (BCBSTX) providers. You may access it through a secure provider portal at www.bcbstx.com. CCC mirrors the ClaimCheck®' auditing rules that BCBSTX has adopted as part of its claim adjudication process. It provides easy access to ClaimCheck payment policies and rules along with clinical rationales, clarifications and source information for ClaimCheck edits.

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<tr><td>Preventive Medicine Evaluation & Management (E&M) Services</td><td>

- Preventive Medicine E&M services should be reported using the age appropriate code from the Preventive Medicine Services section of the most current CPT manual.
- Services rendered should be reported using **99381-99387 for new patients** or **99391-99397 for established patients**. These codes include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic comprehensive preventive medicine examination.
- If an abnormality/ies is encountered, or a preexisting problem is addressed in the process of performing a preventive medicine E&M service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate **Office/Outpatient code 99201-99215** should also be reported.
  - Modifier-25 should be added to the Office/Outpatient code to indicate that a significant; separately identifiable E&M service was provided by the same physician on the same day as the preventive medicine service.

Note: An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive medicine E&M service and which does not require additional work and the performance of the key components of a problem-oriented E&M service should not be reported.

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<tr><td>Immunizations and Ancillary Studies</td><td>

- Immunizations and ancillary studies involving laboratory, radiology, other procedures, or screening tests identified with a specific CPT code are reported separately.
- For immunizations, refer to CPT codes 90465–90474 and 90476–90749.

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<tr><td>Inappropriate Codes</td><td>

- The following **HCPCS codes** are inappropriate for billing services to BCBSTX:
  - G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination
  - S0610 – Annual gynecological examination, new patient
  - S0612 – Annual gynecological examination, established patient
  - S0613 – Annual gynecological examination, clinical breast examination without pelvic examination

Note: The services described by these codes are considered an integral part of the E&M services identified by the Preventive Medicine Services codes. They should not be reported in addition to the Preventive Medicine Services codes.

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<tr><td>Claims Filing</td><td>

- All services provided on the same date of service by the same physician should be submitted on the same claim.

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<tr><td>Member Contract Benefits</td><td>

- Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits.
- Members and their providers have the responsibility for consulting the member's benefit plan to determine if there are exclusions or other benefit limitations applicable, i.e. medical policy, cosmetic, home health, etc.
- Providers are encouraged to contact Customer Service for benefit determination prior to rendering services.

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