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

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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

In this Section

The following topics are covered 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 (formerly Predeterminations)

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 (formerly predeterminations) is recommended for medical necessity to determine benefit coverage. 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**.

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.

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Prior Authorizations and Recommended Clinical Review

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:

- 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 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.

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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

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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

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Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSTX.

Carelon Medical Benefits Management is an independent company that has contracted with BCBSTX to provide utilization management services for members with coverage through BCBSTX.

BCBSTX makes no endorsement, representations or warranties regarding third party vendors and the products and services they offer.