Chapter 8

BILLING INSTITUTIONAL CLAIMS
HOSPITAL AND INSTITUTIONAL BILLING REQUIREMENTS
BY SERVICE CATEGORY

This section provides special billing requirements for each of the services listed below. The member’s benefits may not cover some of these services so it is important to confirm coverage. Also, consult your BCBSTX provider agreement to find out more about billing for any of these services.

Maternity

The billing requirements for maternity care apply to all live and still birth deliveries, and include payment for all associated services, including, but not limited to:

- Room and board for mother (including all nursing care)
- Nursery for baby (including all nursing care)
- Delivery room/surgery suites
- Equipment, laboratory, radiology, pharmaceuticals, and other services incidental to admission.

The maternity care rate covers the entire admission, except for admissions that are approved for extension beyond what is contractually indicated on the continuous inpatient days. In such cases, the inpatient acute care requirements apply for each approved and medically necessary service day for the entire admission, unless otherwise indicated.

Therapeutic abortions, treatment for ectopic and molar pregnancies and similar conditions are excluded from payment under this rate.

Reimbursement for abortions is based on the physician’s certification that the abortion was performed to save the mother’s life, to terminate pregnancy resulting from rape, or to terminate pregnancy resulting from incest. At this time, the Abortion Certification Statement Form and claim must be filed on paper. The signature of the physician must be original script (not stamped or typed). Failure to submit the Abortion Certification Statement Form, or if the form is not completed correctly, will result in denial of your claim. The Abortion Certification Statement Form is located on the TMHP website at www.tmhp.com/TMHP_File_Library/TWHP/WHP%20Certification.pdf.

Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and medically necessary service day in a licensed bed (not covered under another category in this section) and include, but are not limited to:

- Room and board (including all nursing care)
- Surgery and recovery suites
- Emergency room (if connected with admission), urgent care (if connected with admission)
- Equipment, supplies, laboratory, radiology, pharmaceuticals and other services incidental to the admission

Special billing instructions and requirements:

- Utilization Management approval is required for all admissions (except standard vaginal delivery and cesarean sections).
Inpatient Sub-Acute Care

Sub-acute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

The billing requirements for inpatient sub-acute care include each approved and medically necessary service day in a duly licensed and accredited facility at the appropriate level of care. Each inpatient sub-acute care admission is considered a separate admission from any preceding or subsequent acute care admission, and should be billed separately.

Covered services rendered during an admission include, but are not limited to:

- Room and board (including all nursing care)
- Equipment use, supplies, laboratory, radiology, pharmaceuticals and other services incidental to the admission.

All admissions and levels of care require prior approval. In addition, a treatment plan must accompany all sub-acute care admissions including:

- Functional, reasonable, objective and measurable goals within a predictable time frame for each skilled discipline.
- A discharge plan and options that are individually customized and identified from the admission date and that are carried forward from the admission date.
- Weekly summaries for each discipline; biweekly team conference reports are required.

Emergency Room Visits

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency.

The billing requirements for an emergency room visit apply to all emergency cases treated in the hospital emergency room, for patients who do not remain overnight, and cover all diagnostic and therapeutic services provided, including, but not limited to:

- Facility use (including all nursing care)
- Equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the emergency room visit.

Reimbursement for emergency room services relates to the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis.

Please Note: If the emergency room visit results in an admission, then all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care. Consult your contract regarding the 24-hour rule.

Special billing instructions and requirements for ER visits:

- Emergency room visits should be billed with CPT codes 99284, 99285.
- Services billed with CPT codes 99281, 99282, 99283 will be reduced by 40 percent as non-emergent services.
- ICD principal diagnosis codes are required for all services provided in an emergency room setting.
- Bill each service date as a separate line item.
- Revenue codes 0450 to 0452, and 0459 are required, as are CPT codes 99284 and 99285.

Refer all members to the primary care provider of record for follow-up care. Unless clinically required, follow-up care should never occur in the hospital’s emergency department.
Urgent Care Visits
Urgent care refers to non-scheduled, non-emergency hospital services required to prevent serious deterioration of a patient’s health status as a result of an unforeseen illness or injury.

The billing requirements for urgent care visits apply to all urgent care cases treated and discharged from the hospital, outpatient department/emergency room, and include all diagnostic and therapeutic services provided, including, but not limited to:
- Facility use (including all nursing care)
- Equipment, laboratory, radiology, supplies, pharmaceuticals and other services incidental to the visit.

Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

Special billing instructions and requirements:
- Current ICD principle diagnosis codes are required for all services provided in an urgent care setting or designated facility.
- Bill each service date as a separate line item.
- Revenue codes required are 045X, 0516, 0526, 0700 or 072X, as well as CPT codes 99281-83.

Outpatient Laboratory, Radiology and Diagnostic Services
The billing requirements for outpatient laboratory, radiology, and diagnostic services (not included elsewhere) refer to services that include, but are not limited to:
- Clinical laboratory
- Pathology
- Radiology and other diagnostic tests

These billing requirements include services rendered in relation to an outpatient visit for laboratory, radiology or other diagnostic services, including, but not limited to:
- Facility use
- Nursing care (including incremental nursing)
- Equipment
- Professional services (if applicable)
- Specified supplies and all other services incidental to the outpatient visit

Outpatient radiation therapy is excluded from this service category and should be billed under the requirements of the other services category.

Outpatient Surgical Services
The billing requirements for outpatient surgical services apply to each outpatient hospital visit for outpatient surgery services, including, but not limited to:
- Facility use (including nursing care)
- Equipment, supplies, pharmaceuticals, blood, laboratory, radiology, imaging services, implantable prostheses and all other services incidental to the outpatient surgery visit
**Please Note:** Even though a service is classified by the hospital as an outpatient service, if the member is receiving that service in the hospital as of 12 a.m., the hospital should bill at the inpatient diagnostic related grouping (DRG) rate.

For surgery services that are not defined in the surgery grouping, medical records might be requested by BCBSTX for review and determination of surgery grouping.

Special billing instructions and requirements:
- Include CPT/HCPCS codes for each surgical procedure in form locators 44 (HCPCS/RATES). Revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X, 079X and 0975 are required with the appropriate CPT/HCPCS code.
- HIPAA mandates that outpatient surgery should be billed with CPT/HCPCS code.
- Service dates must accompany each procedure (both principal and other). Billing instructions and requirements for outpatient services:
  - CPT/HCPCS codes are required for each service.
  - Bill each service for each date as a separate line item.
  - Use the following required revenue codes with the appropriate CPT/HCPCS code:

<table>
<thead>
<tr>
<th>CPT/HCPCS Codes</th>
<th>Revenue Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>80049 – 85097</td>
<td>94690</td>
</tr>
<tr>
<td>89050 – 89399</td>
<td>94760 – 94762</td>
</tr>
<tr>
<td>91100</td>
<td>95851 – 95857</td>
</tr>
<tr>
<td>93980 – 93990</td>
<td></td>
</tr>
</tbody>
</table>

When the Respiratory Therapy department performs ECG, EEG or EKGs, follow the billing requirements as outlined in this service category; do not apply the outpatient therapy billing requirements. The type of bill field entry must be 13X.
Outpatient Therapies

Outpatient therapy services include physical, occupational, speech and respiratory therapies. An outpatient therapy visit means a single service date. Outpatient therapy visits include, but are not limited to:

- Facility use (including all nursing care)
- Therapist/professional services
- Supplies, equipment, pharmaceuticals and other services incidental to the outpatient therapy visit

Special billing instructions and requirements:

- Bill each service date as a separate line item.
- Required revenue codes are:
  - Respiratory therapy – 041X
  - Physical therapy – 042X
  - Occupational therapy – 043X
  - Speech therapy – 044X
  - Or the applicable CPT/HCPCS codes

Outpatient Infusion Therapy Visit and Pharmaceuticals

The outpatient infusion therapy visit billing requirements apply to each outpatient hospital visit for infusion therapy services, including, but not limited to:

- Facility use (including all nursing care)
- Equipment, professional services, laboratory, radiology, supplies (for example, syringes, tubing, line insertion kits and so on)
- Intravenous solutions (excluding pharmaceuticals), kinetic dosing and other services incidental to the outpatient infusion therapy visit

An outpatient infusion therapy visit means a single service date.

The outpatient infusion therapy pharmaceuticals billing requirements apply to the drugs (for example, chemotherapy, hydration and antibiotics) used during each outpatient visit for infusion therapy services, except for blood and blood products, which are considered other services.

Special billing instructions and requirements:

- Revenue codes 026X, 028X, 0331, 0335 or 0940 are required for each outpatient infusion therapy visit.
- When billing therapeutic aphaeresis claims, use revenue code 0940 or 0949 with 36511-36513, 36515-36516 or 36522 CPT/HCPCS codes; list pharmaceuticals as a separate line item.
- All applicable HCPCS codes are required for all pharmaceuticals when:
  - Billed with revenue codes 0250 to 0252, 0256 to 0259, or 063X; you must include the units with pharmaceutical CPT/HCPCS codes.
  - Billed with revenue codes 026X, 028X, 0331, 0335 or 0940.
  - List each drug for each visit as a separate line item and include a service date.
Hospitals in the BCBSTX network are required to report Provider-Preventable Conditions (PPCs) using Present on Admission (POA) claims. The following is a list of those PPCs for which BCBSTX may not pay claims:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma
  - Fractures
  - Dislocations
  - Intracranial Injuries
- Manifestations of Poor Glycemic Control
  - Diabetic Ketoacidosis
  - Nonketotic Hyperosmolar Coma
  - Hypoglycemic Coma
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection
- Surgical Site Infection Following:
  - Coronary Artery Bypass Graft (CABG)—Mediastinitis
  - Secondary Diabetes with Ketoacidosis
  - Secondary Diabetes with Hyperosmolarity
  - Catheter-Associated Urinary Tract Infection (UTI)
  - Secondary Diabetes with Hyperosmolarity
- Bariatric Surgery
- Laparoscopic Gastric Bypass
- Gastroenterectomy
- Laparoscopic Gastric Restrictive Surgery
- Orthopedic Procedures
  - Spine
  - Neck
  - Shoulder
  - Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement. Not included for Medicaid for pediatric and obstetric populations.
- Surgery on the wrong patient
- Wrong surgery on a patient
- Wrong site surgery
Table of POA Codes

This table includes the Indicator Codes to be used on the hospital claim. Using the codes correctly ensures that you are reimbursed appropriately.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Reimbursable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>The condition was present on admission.</td>
<td>Yes</td>
</tr>
<tr>
<td>N</td>
<td>The condition was not present on admission.</td>
<td>No</td>
</tr>
<tr>
<td>W</td>
<td>The provider determined that it was not possible to document if the condition was present on admission.</td>
<td>Yes</td>
</tr>
<tr>
<td>U</td>
<td>The documentation was insufficient to determine if the condition was present on admission.</td>
<td>No</td>
</tr>
<tr>
<td>Blank</td>
<td>Exempt from POA reporting.</td>
<td>Exempt from POA reporting.</td>
</tr>
</tbody>
</table>

**Note:** If a diagnosis is exempt from POA reporting, providers should leave the POA indicator field blank on the claim. For a list of diagnoses that are exempt from POA reporting, refer to the Texas Medicaid Provider Procedures Manual located at [www.tmhp.com](http://www.tmhp.com).

**Indicator Code Usage and Examples**

Indicator code usage is different for electronic and paper claims:

For electronic claims, the POA indicator codes follow the diagnosis code in the appropriate 837i 2300 HI segment. They must be within 2300 HI01-09 through HI12-09 in accordance with the number of diagnosis codes billed.

Examples of diagnosis codes with PPC data:
- HI*BK: 5770:::::::Y~
- HI*B: 78906~
- HI*BF: 3051:::::::Y*BF:4019:::::::Y*BF:3384:::::::Y*BF:77210:::::::Y*BF:V5869~

For paper claims, the POA Code is the eighth digit of Field Locator (FL) 67, Principal Diagnosis and Secondary Diagnosis fields, FL 67 A-Q. If the diagnosis is exempt from POA reporting, leave this field blank.

**CMS- 1450 (UB-04) CLAIM FORM**

**Who Should Use the CMS-1450 (UB-04) Claim Form?**

All Medicare-approved facilities should bill BCBSTX using the most current version of the CMS-1450 (UB-04) claim form. For help with the claim form, refer to the Sample Section from the CMS-1450 (UB-04).

**Completing a CMS-1450 (UB-04) Claim Form**

Complete all fields for reimbursement. Refer to the Recommended Fields for CMS-1450 (UB-04).
Coding

Standardized code sets are used to ensure that claims are processed in an orderly and consistent manner. The Healthcare Common Procedure Coding System (HCPCS), sometimes called National Codes, provides codes for billing a variety of services. HCPCS consists of two principal subsystems, referred to as Level I and Level II:

- **Level I** consists of Current Procedural Terminology (CPT) codes maintained by the American Medical Association (AMA). CPT codes are represented by five numeric digits.

- **Level II** consists of other codes that identify products, supplies and services not included in the CPT codes, such as ambulance and durable medical equipment (DME). These are sometimes called the alpha-numeric codes because they consist of a single alphabetical letter followed by four numeric digits.

- In some cases, two digit/character modifier codes should accompany the Level I or Level II coding.

**CMS-1450 (UB-04) Revenue Codes**

CMS-1450 (UB-04) revenue codes are required for all institutional claims.

**Inpatient Coding — Institutional**

For institutional inpatient coding, use the guidelines in the following code manuals:

- Current ICD applicable and procedure codes must be in Boxes 74–74e of the CMS-1450 (UB-04) form when the claim indicates a procedure was performed.


- Please refer to your contract for diagnostic related grouping (DRG) information.

**Outpatient Coding — Institutional**

For institutional outpatient coding, use the guidelines in the following code manuals:


- BCBSTX requires that when outpatient services are billed, they must have itemized CPT/HCPCS codes; use of revenue codes only on outpatient claims will result in a delay or denial of the claim for lack of information.

- When using an unlisted CPT/HCPCS code, provide the name of the drug or medication in Box 43 of the CMS-1450 (UB-04) claim.

**Member ID Number**

Use the member’s Medicaid (STAR) or CHIP ID number from BCBSTX’s ID card on all claims submitted. See **Recommended Fields for CMS-1450 (UB-04)** for field descriptions for the CMS-1450 (UB-04) claim form.

Visit the Centers for Medicare and Medicaid Services website at [www.cms.hhs.gov](http://www.cms.hhs.gov) for more information.
### Recommended Fields for CMS-1450 (UB-04)

The following guidelines will assist in completing the CMS-1450 (UB-04) form. ‘M’ indicates a mandatory field. For additional information please refer to the Texas Medicaid Healthcare Partnership (TMHP) website at [www.tmhp.com](http://www.tmhp.com).

<table>
<thead>
<tr>
<th>Field</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 1 (M)</td>
<td>blank</td>
<td>Facility name, address, phone and fax number.</td>
</tr>
<tr>
<td>Field 2</td>
<td>Provider’s Tax ID</td>
<td>Facility pay to - name and address</td>
</tr>
<tr>
<td>Field 3a</td>
<td>PAT CNTL #</td>
<td>Member account number</td>
</tr>
<tr>
<td>Field 3b</td>
<td>MED. REC #</td>
<td>Optional record number.</td>
</tr>
<tr>
<td>Field 4 (M)</td>
<td>TYPE OF BILL</td>
<td>Enter the appropriate three-digit code.</td>
</tr>
<tr>
<td>Field 5 (M)</td>
<td>FED. TAX NO.</td>
<td>Enter the provider’s Federal Tax Identification Number.</td>
</tr>
<tr>
<td>Field 6 (M)</td>
<td>STATEMENT COVERS PERIOD</td>
<td>‘FROM’ and ‘THROUGH’ date(s) covered by the claim being submitted.</td>
</tr>
<tr>
<td>Field 7</td>
<td>blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field 8a–b (M)</td>
<td>PATIENT NAME</td>
<td>Member’s name as it appears on the ID card.</td>
</tr>
<tr>
<td>Field 9a–e (M)</td>
<td>PATIENT ADDRESS</td>
<td>Complete address (number, street, city, state, ZIP code, telephone number).</td>
</tr>
<tr>
<td>Field 10 (M)</td>
<td>BIRTHDATE</td>
<td>Enter the member’s date of birth in MM/DD/YYYY format. For example, September 16, 1963 would be entered as 09/16/1963.</td>
</tr>
<tr>
<td>Field 11 (M)</td>
<td>SEX</td>
<td>Enter the member’s gender.</td>
</tr>
<tr>
<td>Field 12 (M)</td>
<td>ADMISSION DATE</td>
<td>Member’s admission date to the facility in MM/DD/YYYY format.</td>
</tr>
<tr>
<td>Field 13 (M)</td>
<td>ADMISSION HR</td>
<td>Enter the member’s admission hour to the facility in military time (00 to 23) format.</td>
</tr>
<tr>
<td>Field</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Field 14 (M) | ADMISSION TYPE | Type of admission. A qualifier is mandatory if a date is entered. Enter the applicable qualifier to identify which date is being reported.  
431 – Onset of Current Symptoms or illness  
484 – Last Menstrual Period  
Enter the qualifier to the right of the vertical, dotted lines |
| Field 15 (M) | ADMISSION SRC   | Source of admission. A qualifier is mandatory if a date is entered. Enter the applicable qualifier to identify which date is being reported.  
454 – Initial Treatment  
304 – Latest Visit or Consultation  
453 – Acute Manifestation of a Chronic Condition  
439 – Accident  
455 – Last X-ray  
471 – Prescription  
090 – Report Start (Assumed Care Date)  
090 – Report End (Relinquished Care Date)  
444 – First Visit or Consultation  
Enter the qualifier between the left-hand set of vertical, dotted lines. The ‘Other Date’ identifies additional date information about the patient’s condition or treatment. |
<p>| Field 16 (M) | DHR            | Member’s discharge hour from the facility in MM/DD/YYYY format.                                                                                   |
| Field 17 (M) | STAT           | Member status.                                                                                                                                 |
| Field 18–28 | CONDITION CODES | Enter condition code (81) X0 – X9, if applicable.                                                                                             |
| Field 29  | ACDT STATE      | Accident state. Leave blank.                                                                                                                  |
| Field 30  | blank           | Leave blank.                                                                                                                                     |</p>
<table>
<thead>
<tr>
<th>Field</th>
<th>Box Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Field 31–34 (M)</td>
<td>OCCURRENCE CODE OCCURRENCE DATE</td>
<td>Enter the occurrence codes (42).</td>
</tr>
<tr>
<td>Field 35–36</td>
<td>OCCURRENCE SPAN (CODE, FROM, &amp; THROUGH)</td>
<td>Enter the dates in MM/DD/YYYY format.</td>
</tr>
<tr>
<td>Field 37</td>
<td>blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field 38</td>
<td>blank</td>
<td>Enter the responsible party name and address, if applicable.</td>
</tr>
<tr>
<td>Field 39–41</td>
<td>VALUE CODES (CODE &amp; AMOUNT)</td>
<td>Enter the appropriate value code (or codes), with the appropriate amount(s).</td>
</tr>
<tr>
<td>Field 42 (M)</td>
<td>REV. CD.</td>
<td>Revenue code. Revenue codes are required for all institutional claims.</td>
</tr>
<tr>
<td>Field 43 (M)</td>
<td>DESCRIPTION</td>
<td>Description of services rendered.</td>
</tr>
<tr>
<td>Field 44 (M)</td>
<td>HCPCS/RATE/HIPPS CODE</td>
<td>Enter the accommodation rate per day for inpatient services or HCPCS/CPT code for outpatient services.</td>
</tr>
<tr>
<td>Field 45 (M)</td>
<td>SERV. DATE</td>
<td>Date of services rendered.</td>
</tr>
<tr>
<td>Field 46 (M)</td>
<td>SERV. UNITS</td>
<td>Number/units of occurrence for each line or service being billed.</td>
</tr>
<tr>
<td>Field 47 (M)</td>
<td>TOTAL CHARGES</td>
<td>Total charge for each line of service being billed.</td>
</tr>
<tr>
<td>Field 48</td>
<td>NON-COVERED CHARGES</td>
<td>Enter any non-covered charges.</td>
</tr>
<tr>
<td>Field 49</td>
<td>blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field 50 (M)</td>
<td>PAYER NAME</td>
<td>Payer identification. Enter any third-party payers.</td>
</tr>
<tr>
<td>Field 51 (M)</td>
<td>HEALTH PLAN ID</td>
<td>Enter the TPI number.</td>
</tr>
<tr>
<td>Field 52</td>
<td>REL. INFO</td>
<td>Release of Information certification indicator.</td>
</tr>
<tr>
<td>Field 53</td>
<td>ASG BEN.</td>
<td>Assignment of Benefits certification indicator.</td>
</tr>
<tr>
<td>Field 54</td>
<td>PRIOR PAYMENTS</td>
<td>Prior payments.</td>
</tr>
<tr>
<td>Field 55</td>
<td>EST. AMOUNT DUE</td>
<td>Estimated amount due.</td>
</tr>
<tr>
<td>Field 56</td>
<td>NPI</td>
<td>Enter the NPI number.</td>
</tr>
<tr>
<td>Field 57 (M)</td>
<td>OTHER PRIV ID</td>
<td>In the OTHER field, enter the NPI number. Enter the other provider ID in the PRIV ID field, if applicable.</td>
</tr>
<tr>
<td>Field 58 (M)</td>
<td>INSURED’S NAME</td>
<td>Enter the member’s name.</td>
</tr>
<tr>
<td>Field</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Field 59</td>
<td>P. REL</td>
<td>Patient’s relation to insured. Leave blank if member is the insured.</td>
</tr>
<tr>
<td>Field 60 (M)</td>
<td>INSURED’S UNIQUE ID</td>
<td>Insured’s ID number – Certificate number on the member’s ID card.</td>
</tr>
<tr>
<td>Field 61</td>
<td>GROUP NAME</td>
<td>Insured group name. Enter the name of any other health plan.</td>
</tr>
<tr>
<td>Field 62 (M)</td>
<td>INSURANCE GROUP NO.</td>
<td>Insurance group number. Enter the policy number of any other health plan.</td>
</tr>
<tr>
<td>Field 63</td>
<td>TREATMENT AUTHORIZATION CODES</td>
<td>Authorization number or authorization information must be entered in this field.</td>
</tr>
<tr>
<td>Field 64</td>
<td>DOCUMENT CONTROL NUMBER</td>
<td>The control number assigned to the original bill.</td>
</tr>
<tr>
<td>Field 65</td>
<td>EMPLOYER NAME</td>
<td>Name of organization from which the insured obtained the other policy.</td>
</tr>
<tr>
<td>Field 66 (M)</td>
<td>DX</td>
<td>Enter the diagnosis and procedure code qualifier (ICD version indicator).</td>
</tr>
<tr>
<td>Field 67 (M)</td>
<td>blank</td>
<td>Principal diagnosis code. Enter the ICD diagnostic code.</td>
</tr>
<tr>
<td>Field 67a–q (M)</td>
<td>blank</td>
<td>Other diagnostic codes. Enter the ICD diagnostic codes, if applicable.</td>
</tr>
<tr>
<td>Field 68</td>
<td>blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field 69</td>
<td>ADMITDX</td>
<td>Admitting diagnosis code. Enter the ICD diagnostic code, if applicable.</td>
</tr>
<tr>
<td>Field 70a–c (C)</td>
<td>PATIENT REASON DX</td>
<td>Enter the member’s reason for this visit, if applicable.</td>
</tr>
<tr>
<td>Field 71</td>
<td>PPS CODE</td>
<td>Prospective payment system (PPS) code. Leave blank.</td>
</tr>
<tr>
<td>Field 72</td>
<td>ECI</td>
<td>External cause of injury code. Enter the ICD diagnostic code, if applicable.</td>
</tr>
<tr>
<td>Field 73</td>
<td>blank</td>
<td>Enter the benefit code, if applicable.</td>
</tr>
<tr>
<td>Field 74 (M)</td>
<td>PRINCIPAL PROCEDURE (CODE/DATE)</td>
<td>ICD principal procedure code and dates, if applicable.</td>
</tr>
<tr>
<td>Field</td>
<td>Box Title</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Field 74a–e (M)</td>
<td>OTHER PROCEDURE (CODE/DATE)</td>
<td>Other procedure codes.</td>
</tr>
<tr>
<td>Field 75</td>
<td>blank</td>
<td>Leave blank.</td>
</tr>
<tr>
<td>Field 76 (M)</td>
<td>ATTENDING</td>
<td>Enter the NPI number in the NPI field.</td>
</tr>
<tr>
<td>Field 77 (M)</td>
<td>OPERATING</td>
<td>Enter the NPI number in the NPI field.</td>
</tr>
<tr>
<td>Field 78–79 (M)</td>
<td>OTHER</td>
<td>Enter the NPI number in the NPI field.</td>
</tr>
<tr>
<td>Field 80</td>
<td>REMARKS</td>
<td>Use this field to explain special situations.</td>
</tr>
<tr>
<td>Field 81a–c</td>
<td>CC</td>
<td>Enter additional or external codes, if applicable.</td>
</tr>
</tbody>
</table>

**SERVICES THAT MUST BE BILLED TO THE HEALTH AND HUMAN SERVICES COMMISSION (HHSC)**

**STATE SERVICES**

- Community Resource Coordination Groups (CRCGs)
- Early Childhood Intervention (ECI) Program - Case Management (Therapies are billed to the plan)
- Local school districts (SHARS)
- Health and Human Services Commission’s Medical Transportation Program (MTP);
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children’s Vocational Discovery and Development Program;
- Texas Department of State Health (DSHS) services, including community behavioral health programs, Title V Maternal and Child Health, Children with Special Health Care Needs (CSHCN) Programs;
- Other state and local agencies and programs such as food stamps, the Women, Infants, and Children’s (WIC) Program and Case Management for Children and Pregnant Women (CPW)
- Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population

Providers of these services must submit claims for these services to the HHSC claims administrator for reimbursement.
ANCILLARY BILLING REQUIREMENTS BY SERVICE CATEGORY

This section provides special billing requirements applicable to each service listed below. The member’s benefits may not cover some of the services listed. Please be sure to confirm benefit coverage. Also, consult your BCBSTX Provider Agreement for specifics regarding billing for any of these or other services.

Most ancillary claims submitted are for:
- Laboratory and diagnostic imaging on a CMS-1500 form.
- Durable medical equipment on a CMS-1500 form. Other types of devices are also described.

Laboratory and Diagnostic Imaging

When filling out the CMS-1500 form for laboratory and diagnostic imaging, refer to the following guidelines:

- **Billing requirements per contract**: BCBSTX’s billing requirements apply to all member claims, except some services administered through Texas HHSC and other state contract programs.
- **System edits**: Edits are in place for both electronic and paper claims. Claims not submitted in accordance with requirements cannot be readily processed, and most likely will be returned.
- **Valid coding**: For claims submitted to BCBSTX, valid HCPCS, CPT or revenue codes are required for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
- **Split year claims**: Services that begin before or in December and extend beyond December 31, should be billed as a split claim at calendar year end. Two CMS-1500s must be used and must be submitted together.
- **Contract change during course of treatment**: A provider’s reimbursement may be affected by a contract change during a course of treatment. You are required to split the dates of service in order to be reimbursed at the new rate.
- **Itemization**: Services itemization is required when the ‘from’ and ‘through’ service dates are the same.
- **Medical records**: Medical records for certain procedures might be requested for determination of medical necessity.
- **Modifiers**: Use modifiers in accordance with your specific billing instructions.
- **Unlisted procedures**: There may be services or procedures performed by physicians that are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, BCBSTX needs a description of the service to calculate the appropriate reimbursement, and medical records may be requested.
- **CPT code 99070**: This code, for (supplies and materials provided over and above those usually included with the office visit or other services, is not accepted by BCBSTX. Health care professionals are to use HCPCS Level II codes, which give a detailed description of the service provided. BCBSTX will pay for surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be payable separately.
DURABLE MEDICAL EQUIPMENT

Durable Medical Equipment (DME) is covered when prescribed to preserve bodily functions or prevent disability.

Durable Medical Equipment Prior Authorization

All custom-made DME requires prior authorization. Some other DME services may also require prior authorization. Prior to dispensing, please contact our Utilization Management (UM) department. Services that require prior authorization will be denied if approval is not obtained from the UM department.

The presence of a Healthcare Common Procedure Coding System (HCPCS) code does not necessarily mean that the benefit is covered or that payment will be made for a particular service. Some DME codes may be by report and therefore require additional information for prior authorization, as well as for processing at point of claim.

Durable Medical Equipment Billing

Durable Medical Equipment (DME) providers should bill with the appropriate modifier to identify rentals versus purchases (new or used). Claims submitted without the appropriate modifier will be reimbursed at rental price.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NU</td>
<td>New</td>
</tr>
<tr>
<td>UE</td>
<td>Used</td>
</tr>
<tr>
<td>RR</td>
<td>Rental</td>
</tr>
</tbody>
</table>

Follow these general guidelines for DME billing:

- Use HCPCS codes for DME or supplies
- Use miscellaneous codes (such as E1399) when an HCPCS code does not exist for that particular item of equipment. An unlisted code like E1399 cannot be used to describe expensive or difficult-to-order items when codes for those items exist.
- Unlisted codes will not be accepted if valid HCPCS codes exist for the DME and supplies
- Attach the manufacturer’s invoice to the claim if using a miscellaneous or unlisted code (such as E1399). The invoice must be from the manufacturer, not the office making a purchase.
- Catalog pages are not acceptable as a manufacturer’s invoice

Durable Medical Equipment Rental

Durable Medical Equipment (DME) rentals require medical documentation from the prescribing doctor. Most DME is dispensed on a rental basis only, such as oxygen tanks or concentrators. Rented items remain the property of the DME provider until the purchase price is reached.

DME providers should use normal equipment collection guidelines. BCBSTX is not responsible for equipment not returned by members.

Charges for rentals exceeding the reasonable charge for a purchase are not accepted, and rental extensions may be obtained only on approved items.
Durable Medical Equipment Purchase

Durable Medical Equipment (DME) may be reimbursed on a rent-to-purchase basis over a period of 10 months, unless specified otherwise at the time of review by our UM department.

Wheelchairs/Wheeled Mobility Aids

Medicaid guidelines are followed when calculating payments for by report (customized) wheelchair claims.

Claims documentation must include:

- Item description
- Manufacturer name
- Model number
- Catalog number
- Completion of the Reserved for Local Use field (Box 19) on the CMS-1500 claim form with the total MSRP of the wheelchair, including all wheelchair accessories, modifications, or replacement parts, and the name of the employed Rehabilitation and Assistive Technology of America (RESNA) certified technician.

- You must mark each catalog page or invoice line so it can be matched to the appropriate claim line.
- For wheeled mobility aids, in addition to the above, the invoice must be an amount published by the manufacturer before August 1, 2003. If the item was not available before then, you must list the date of availability in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form. The catalog page that initially published the item must be attached to the claim.

Wheelchair claims from manufacturers billing as providers must include:

- The MSRP from a catalog page dated before August 1, 2003. If the item was not available before August 1, 2003, the manufacturer’s invoice must accompany the claim.
- The initial date of availability must be documented in the Reserved for Local Use field (Box 19) of the CMS-1500 claim form.

Modifiers

For a listing of DME modifier codes, please access Appendix 1 of the HCPCS 2006 publication available from the American Medical Association (AMA), or log on to their website, www.ama-assn.org for online access.

OTHER SERVICE TYPES

Ambulance

Ambulance providers, including municipalities, should use a CMS-1500 form to bill for ambulance services.

Use appropriate two-digit origin and destination codes that describe the ‘to’ and ‘from’ locations.

More information about BCBSTX’s requirements for ambulance services can be found in the Texas Medicaid Provider Procedures Manual, available on this website www.tmhp.com.
Ambulatory Surgical Centers
Most outpatient surgery delivered in an ambulatory surgical center needs pre-authorization.
Form CMS-1500: Free-standing ambulatory surgical centers bill on a CMS-1500 form. Check your BCBSTX Provider Agreement for more information.

Dialysis
All dialysis care must be pre-authorized (except where Medicare is primary payer). Contact BCBSTX’s UM department for authorization prior to delivery of service.
Dialysis centers and other entities which perform dialysis should use the CMS-1450 (UB-04) form to bill for dialysis services.
More information about BCBSTX requirements for dialysis services can be found in the Texas Medicaid Provider Procedures Manual, available on this website www.tmhp.com.

Home Health Care
All home health care must be pre-authorized. Contact Utilization Management for authorization prior to delivery of the service.
When billing for a home health visit use a CMS-1450 (UB-04) form.
When billing for supplies and equipment used for a home health visit, please refer to the DME section for billing. For injections and home infusion therapy, the following Home Infusion Therapy section offers billing guidelines.

Home Infusion Therapy
Home Infusion Therapy is billed using a CMS-1500 form.
• Submit all claims within the contracted filing limit of 95 days from date of service.
• Authorization is required from Utilization Management for all infusion therapy and should be obtained before the services are rendered.
• Use the appropriate HCPCS injection codes to bill for all injections listed. The codes are available on the TMHP website at www.tmhp.com.
• Use HCPCS code J3490 along with the National Drug Code (NDC) for billing injections only if an appropriate injection code is not found.
• You must use the appropriate codes to bill for medical supplies and accessories shown in the medical supplies lists of the Provider Manual found on the TMHP website at www.tmhp.com.
• By Report HCPCS codes, including HCPCS code A9999, for supplies and accessories are reimbursed at the lesser of:
  – The amount billed, or
  – The manufacturer’s purchase invoice amount, plus a 24 percent markup.
Hospice
All hospice care must be pre-authorized. Contact Utilization Management for authorization prior to hospice admission.

Bill hospice services on the CMS-1450 (UB-04) form.
• For BCBSTX members, the Hospice Care section of the TMHP Manual provides detailed billing instructions. Click the following link www.tmhp.com.

Occupational Therapy
All occupational therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management for authorization prior to delivery of services. The occupational therapy setting determines the correct billing form:
• Form CMS-1500: When providing services in an office, clinic, or outpatient setting.
• Form UB-04: for occupational therapists affiliated with home health agencies and providing services in a patient’s home.

Physical Therapy
All physical therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management for authorization prior to delivery of services.

The physical therapy setting determines the correct billing form:
• Form CMS-1500: When providing services in an office, clinic setting, or outpatient setting.
• Form CMS-1450 (UB-04): When providing services in a rehabilitation center.
• Form UB-04: for physical therapists affiliated with home health agencies and providing services in a patient’s home.

Physical therapy is coded using HCPCS codes. When completing claims do not enter the decimal points in the ICD codes or the dollar amounts. Do not include hyphens when entering modifiers.

Skilled Nursing Facilities
All Skilled Nursing Facility (SNF) care must be pre-authorized. Contact Utilization Management for authorization prior to SNF admission.

Form CMS-1450 (UB-04): SNF care is billed using a CMS-1450 (UB-04) form. Use codes 0550, 0551, 0552, 0559, 90300-903XX.

Speech Therapy
All speech therapy must be pre-authorized. Evaluations do not require pre-authorization. Contact Utilization Management for authorization prior to delivery of services.

The speech therapy setting determines the correct billing form:
• Form CMS-1500: When providing services in an office, clinic, or outpatient setting.
• Form UB-04: for speech therapists affiliated with home health agencies and providing services in a patient’s home.
ADDITIONAL BILLING RESOURCES
The following references provide detailed instructions on uniform billing requirements:
• Healthcare Common Procedure Coding System (HCPCS), National Level II (current year).
• ICD (current edition), Volumes 1, 2, 3 (current year). Practice Management Information Corporation.

CODE TABLES
The codes listed below are examples of some of the codes that, in the past, have been frequently utilized by providers in our Medicaid programs. Use professional judgment to determine the most appropriate code for the service rendered.

CPT codes are routinely updated for both additions and deletions. This list represents our best efforts to accurately reflect currently approved CPT codes as of the date of publication of this manual. The most current version of the CPT manual should be used for full descriptions of the codes.

Please note: Global Billing is not accepted. All charges must be itemized.

CPT CODES FOR EVALUATION AND MANAGEMENT
Office or Other Outpatient Services, New Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are self-limited or minor.</td>
</tr>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of low to moderate severity.</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of moderate severity.</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of moderate complexity, moderate to high severity.</td>
</tr>
<tr>
<td>99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient, the presenting problems are of high complexity; moderate to high severity.</td>
</tr>
</tbody>
</table>
### Office or Other Outpatient Services, Established Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are minimal.</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are self-limited or minor.</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are of low to moderate severity.</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are of moderate complexity, moderate to high severity.</td>
</tr>
<tr>
<td>99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient, the presenting problems are of high complexity, moderate to high severity.</td>
</tr>
</tbody>
</table>

### Office or Other Outpatient Consultations, New or Established Patient

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99241</td>
<td>Office consultation for a new or established patient, the presenting problems are self-limited or minor.</td>
</tr>
<tr>
<td>99242</td>
<td>Office consultation for a new or established patient, the presenting problems are of low to moderate severity.</td>
</tr>
<tr>
<td>99243</td>
<td>Office consultation for a new or established patient, the presenting problems are of moderate severity.</td>
</tr>
<tr>
<td>99244</td>
<td>Office consultation for a new or established patient, the presenting problems are of moderate complexity, moderate to high severity.</td>
</tr>
<tr>
<td>99245</td>
<td>Office consultation for a new or established patient, the presenting problems are of high complexity, moderate to high severity.</td>
</tr>
</tbody>
</table>
Other Services

The following is a list of procedure codes that include other services.

<table>
<thead>
<tr>
<th>HCPCS/CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>46608</td>
<td>Anoscopy; with removal of foreign body.</td>
</tr>
<tr>
<td>57415</td>
<td>Removal of impacted vaginal foreign body (separate procedure) under anesthesia.</td>
</tr>
<tr>
<td>59840</td>
<td>Dilation and curettage — used to induce a first trimester abortion, for termination of a pregnancy in the first 12-14 weeks of gestation.</td>
</tr>
<tr>
<td>59841</td>
<td>Dilation and curettage — used to induce a second trimester abortion, for termination of a pregnancy after 12-14 weeks of gestation.</td>
</tr>
<tr>
<td>99170</td>
<td>Anogenital examination with colposcopic magnification in childhood for suspected trauma.</td>
</tr>
</tbody>
</table>

Medicaid Modifier Codes for Billing Medicaid Services

This table provides modifier codes for billing Medicaid services.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SK</td>
<td>Members of high-risk population</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
</tr>
</tbody>
</table>