FirstChoice VIP CARE PLUS by Select Health of South Carolina | Healthy Connections PRIME
FirstChoice VIP CARE. by Select Health of South Carolina
FAST FACTS Important Information for Our Providers

February 2025	Claims News	Issue # 1

Common Errors on Claims Submissions

First Choice VIP Care Plus and First Choice VIP Care have created and posted an updated guide for both the CMS-1500 and UB-04 required fields and billing guidelines for the mandated 5010 837 formats to ensure your claims are submitted correctly. Please reference this guide to avoid submitting claims with errors. You can find this document on our websites at: www.firstchoicevipcareplus.com and www.firstchoicevipcare.com under Provider > Resources > Common Errors for Claims Submissions.

Invoice Pricing

First Choice VIP Care Plus and First Choice VIP Care prices some CPT® and HCPCS codes using invoices. Please note that failure to submit an invoice, submitting unclear invoices, or submitting incomplete invoices could result in claim rejections.

Modifiers 76

First Choice VIP Care Plus and First Choice VIP Care have noticed an increase in duplicate billing of modifier 76. To avoid claim denials and future appeals, we are providing guidance on how to properly submit a claim when applying this modifier.

Modifier 76 defines **a repeat procedure or service, on the same day, by the same physician or other qualified healthcare professional (QHP)**. Use modifier 76:

- To indicate a procedure or service was repeated subsequent to the original procedure or service.
- On procedure codes that cannot be quantity billed.

Claim submission instructions:

- Use modifier 76 on a separate claim line with the number of repeated services.
- Do not report modifier 76 on multiple claim lines, to avoid duplicate claim line denials.
- Bill all services performed on one day on the same claim to avoid duplicate claim denials.
- Documentation must support the use of the modifier.

Modifier 77

Modifier 77 is used to indicate a procedure or service was **repeated by another physician or other qualified healthcare professional in a separate encounter on the same day**. Use modifier 77:

- Add modifier 77 to the professional component of an x-ray or electrocardiogram (EKG) procedure when more than one physician provides the interpretation and report.
- We will reimburse a second interpretation of the same EKG or x-ray only under unusual circumstances, such as:
  - A questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed, or
  - A change in diagnosis resulting from a second interpretation.

Note: Absent these circumstances, we will reimburse only the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient.

Claim submission instructions:

If performing repeat procedures on the same day:

- Report each procedure on separate claims.
- For initial claim list the procedure code once **without** modifier 77 and the second claim list the procedure code **with** modifier 77.
- Do not use the units' field to indicate the procedure was performed more than once on the same day.
- Add modifier 77 when billing for multiple services on a single day and the service cannot be quantity billed.
- Report the unusual circumstances to support the use of the modifier in the narrative description of the CMS-1500 claim form or the EDI equivalent. If data cannot be written in the narrative, documentation must be submitted.

Note: Failure to report modifier 77 and the unusual circumstances in the narrative portion for the claim or the EDI equivalent will result in a claim rejection.

Claim Disputes

Providers may dispute the way a claim was paid or processed. **Claim disputes must be submitted within 180 days of the initial remittance advice date.** Providers may use the Claims Dispute form located on our website or a written request, which must include the following information:

- Submitter contact information (name, phone number).
- Provider information (name, phone number, NPI number, Tax ID number).
- Member information (name, Date of Birth, member ID number).
- Claim information (claim number, Date of Service, billed amount).
- Reason for dispute.
- Any documentation which supports your position that the plan's reimbursement is not correct.

Claims Disputes may be submitted via:

- Fax:
  - FCVIPCP - **1-888-545-0069**
  - FCVIPC - **1-888-599-1475**
- Mail using the Paper Claims Submission address.