Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠and MyBlue Health℠ Provider Manual – Filing Claims - Claim Review Process

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.

In this Section

The following topics are covered in this section:

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

Claim Review Process Overview

Review this section for information on refunds and recoupments and submitting adjustment requests.

Capitated Medical Groups - 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.

Claim Review Process

The **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health Plans** have two claim review levels available to health care providers.

Claim review requests must be submitted in writing on the **"**Claim Review Form**"**. This form may be found on the BCBSTX website at bcbstx.com/provider in Forms under the Education & Reference Center tab.

At the time the claim review request is submitted, please attach any additional information you wish to be considered in the claim review process. This information may include:

- Reason for claim review request
- Progress notes
- Operative report
- Diagnostic test results
- History and physical exam
- Discharge summary
- Proof of timely filing

Note: If you are submitting additional information due to receiving a letter from BCBSTX requesting it, it should be submitted using the letter received or the Additional Information Form**.** If you need to submit a corrected claim, you should submit it electronically or if you must submit paper, it should include a Corrected Claim Form**.** These forms can be found under Forms under the Education and Reference section on the bcbstx.com/provider website.

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Proof of Timely Filing

For those claims which are being reviewed for timely filing, the **Plans** will accept the following documentation as acceptable proof of timely filing:

- Texas Department of Insurance (TDI) Mail Log
- Certified Mail Receipt (only if accompanied by TDI mail log)
- Availity Electronic Batch (EBR) Response Reports
- Above documentation indicating that the claim was filed with the wrong division of Blue Cross and Blue Shield of Texas
- Documentation from the **Plan** indicating claim was incomplete
- Documentation from the **Plan** requesting additional information
- Primary carrier's EOB indicating claim was filed with primary carrier within the timely filing deadline.

Mail the "Claim Review" form, along with any attachments, to the appropriate address indicated on the form.

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Claims Reviews, Dispute Types & Timeframe for Requests

There are two (2) levels of claim reviews available to you. For the following circumstances, the 1st claim review must be requested within the corresponding timeframes outlined below:

DISPUTE TYPE	TIMEFRAME FOR REQUEST
Audited Payment	Within **45** days following the receipt of written notice of request for refund due to audited payment
Overpayment	Within **45** days following the receipt of written notice of request for refund due to overpayment
Claim Dispute	Within **180** days following the check date/date of the **Plan's** Explanation of Payment (EOP), or the date of the BCBSTX Provider Claims summary (PCS), for the claim in dispute

The **Plans** will complete the 1st claim review within **45** days following the receipt of your request for a 1st claim review.

- You will receive a written notification of the claim review determination

If the claim review determination is not satisfactory to you, you may request a 2nd claim review. The 2nd claim review must be requested within **15** days following your receipt of the 1st claim review determination.

- The **Plans** will complete the 2nd claim review within **30** days following the receipt of your request for a 2nd claim review.
- You will receive written notification of the claim review determination.
- The claim review process for a specific claim will be considered complete following your receipt of the 2nd claim review determination.

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Recoupment Process

Recoupment Process
The Refund Policy for the **Plans** states that the **Plan** has 180 days following the payee's receipt of an overpayment to notify a health care provider that the overpayment has been identified and to request a refund.* For additional information on the Plan's Refund Policy, including when a health care provider may submit a claim review and when an overpayment may be placed into recoupment status, please refer to the **"Refund Policy – Blue Essentials, Blue Advantage HMO, Blue Premier or MyBlue Health"** further on in Section F of this **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider – Provider Manual**. In some unique circumstances a health care provider may request, in writing, that **the Plan** reviews all claims processed during a specified period; in this instance all underpayments and overpayments will be addressed on a claim-by-claim basis. *** Notes:** ♦ The refund request letter may be sent at a later date when the claim relates to **Plan** accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including: • Self-Funded ERISA (Employee Retirement Income Security Act • Indemnity Plans • Medicaid, Medicare and Medicare Supplement • Federal Employees Health Benefit Plan • Self–funded governmental, school and church health plans • Out–of–State Blue Cross and Blue Shield plans (Blue Card) • Out–of–Network (non–participating) providers • Out–of–state provider claims including Away from Home Care • Overpayments due to a settlement or a finding of medical malpractice or negligence that does not occur within the 180 days

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Recoupment Process, cont.

Recoupment Process
♦ Refund requests resulting from settlement or finding of medical malpractice or negligence shall be due within 5 business days, and absent a mutual agreement, Blue Essentials will recover the full amount by offsetting current claims as described in this Refund Policy. When a health care provider's overpayment is placed into a recoupment status, the claims system will automatically off-set future claims payment and generate a Provider Claims Summary (PCS) to the health care provider (Recoupment Process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable **Plan** claim(s). To view an example of a recoupment, please refer to the sample PCS below in Section F in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health – Provider Manual.**

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Sample PCS Recoupment

DATE: MM/DD/YY
PROVIDER NUMBER: 0001112222
CHECK NUMBER: 123456789
TAX IDENTIFICATION NUMBER: 987654321

1 2 3 4

5 **ABC MEDICAL GROUP**
123 MAIN STREET
ANYTOWN, TX 70000

ANY MESSAGES WILL APPEAR ON PAGE 1

6 PATIENT: JOHN DOE
7 PERF PRV: 1234567890
8 CLAIM NO: 00001234567890C

9 IDENTIFICATION NO: P06666-XOC123456789
10 PATIENT NO: 12345KB

11 FROM/TO DATES	12 PS*	13 PAY	14 PROC CODE	15 AMOUNT BILLED	16 ALLOWABLE AMOUNT	17 SERVICES NOT COVERED	18 DEDUCTIONS/ OTHER INELIGIBLE	19 AMOUNT PAID
02/09 – 02/09/12	03	HMO	99213	76.00	50.52	(1) 25.48	0.00	50.52
				76.00	50.52	25.48	0.00	50.52

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $50.52

DEDUCTIONS/OTHER INELIGIBLE

TOTAL SERVICES NOT COVERED: 25.48
PATIENT'S SHARE: 0.00

PROVIDER CLAIMS AMOUNT SUMMARY

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NUMBER OF CLAIMS:	1	AMOUNT PAID TO SUBSCRIBER:	$0.00
AMOUNT BILLED:	$76.00	AMOUNT PAID TO PROVIDER:	$50.52
AMOUNT OVER MAXIMUM ALLOWANCE:	$25.48	RECOUPMENT AMOUNT:	$31.52
AMOUNT OF SERVICES NOT COVERED:	$25.48	NET AMOUNT PAID TO PROVIDER:	$19.00
AMOUNT PREVIOUSLY PAID:	$0.00		

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* PLACE OF SERVICE (PS)
03 PHYSICIAN'S OFFICE.

25 MESSAGES:

(1).CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICE PROVIDED BY A PARTICIPATING PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.

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Professional Provider Claim Summary Field Explanations:

1	**Date**	Date the summary was finalized
2	**Provider Number**	Provider's NPI
3	**Check Number**	The number assigned to the check for this summary
4	**Tax Identification Number**	The number that identifies your taxable income
5	**Provider or Group Name and Address**	Address of the provider/group who rendered the services
6	**Patient**	The name of the individual who received the service
7	**Performing Provider**	The number that identifies the provider that performed the services
8	**Claim Number**	The Blue Shield number assigned to the claim
9	**Identification Number**	The number that identifies the group and member insured by BCBSTX
10	**Patient Number**	The patient's account number assigned by the provider
11	**From/To Dates**	The beginning and ending dates of services
12	**PS**	Place of service
13	**PAY**	Reimbursement payment rate that was applied in relationship to the member's policy type
14	**Procedure Code**	The code that identifies the procedure performed
15	**Amount Billed**	The amount billed for each procedure/service
16	**Allowable Amount**	The highest amount BCBSTX will pay for a specific type of medical procedure.
17	**Services Not Covered**	Non-covered services according to the member's contract
18	**Deductions/Other Ineligible**	Program deductions, copayments, and coinsurance amounts
19	**Amount Paid**	The amount paid for each procedure/service
20	**Amount Paid to Provider for This Claim**	The amount Blue Shield paid to provider for this claim
21	**Total Services Not Covered**	Total amount of non-covered services for the claim
22	**Patient's Share**	Amount patient pays. Providers may bill this amount to the patient.
23	**Provider Claims Amount Summary**	How all of the claims on the PCS were adjudicated
24	**Place of Service (PS)**	The description for the place of service code used in field 12
25	**Messages**	The description for messages relating to: non-covered services, program deductions, and HMO reductions

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Refund Policy

Refund Policy Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health
The **Plans** strive to pay claims accurately the first time; however, when payment errors occur, the **Plan** needs your cooperation in correcting the error and recovering any overpayment. **When a health care provider identifies an overpayment:** • If you identify a refund due to the **Plans**, please submit your refund to the following address: Blue Cross and Blue Shield of Texas Refund and Recovery Dept. 0695 P.O. Box 120695 Dallas, TX 75312-0695 • View Provider Refund Form **When the Plan Identifies an Overpayment:** If the **Plan** identifies an overpayment, a refund request letter will be sent to the payee within 180 days following the payee's receipt of the overpayment that explains the reason for the refund and includes a remittance form and a postage-paid return envelope. In the event that the **Plan** does not receive a response to their initial request, a follow-up letter is sent requesting the refund. • Within 45 days following its receipt of the initial refund request letter *(Overpayment Review Deadline)*, the health care provider may request a claim review of the overpayment determination by the **Plan** by submitting a Claim Review form in accordance with the Claim Review Process referred to below. In determining whether this deadline has been met, the **Plan** will presume that the refund request letter was received on the 5th business day following the date of the letter.

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Refund Policy, cont.

Refund Policy
• Within 45 days following its receipt of the initial refund request letter *(Overpayment Review Deadline)*, the health care provider may request a claim review of the overpayment determination by the **Plan** by submitting a Claim Review form in accordance with the Claim Review Process referred to below. In determining whether this deadline has been met, **the Plan** will presume that the refund request letter was received on the 5th business day following the date of the letter. • If the **Plan** does not receive payment in full within the Overpayment Review Deadline, they will recover the overpayment by offsetting current claims reimbursement by the amount due the **Plan** *(refer to Recoupment Process in this provider manual)* after the later of the expiration of the Overpayment Review Deadline or the completion of the Claim Review Process provided that the health care provider has submitted the Claim Review form within the Overpayment Review Deadline. • For information concerning the Recoupment Process, please refer to the "Recoupment Process" above in this **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider – Provider Manual**. ***Note:*** *In some unique circumstances a health care provider may request, in writing, that the **Plan** review all claims processed during a specified period; in this instance all underpayments* and overpayments will be addressed on a claim-by- claim basis.

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual – Filing Claims - Claim Review Process

Refund Policy, cont.

Refund Policy
For additional information or if you have questions regarding the Refund Policy, please contact Provider Customer Services as follows: **1-877-299-2377** for **Blue Essentials** **1-800-451-0287** for **Blue Advantage HMO** or **MyBlue Health** **1-800-876-2583** for **Blue Premier** If you want to request a review of the overpayment decision, please view the Claim Review Process along with the Claim Review Form & Instructions within this Section F in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health – Provider Manual**. You can also locate the Claim Review Form and Instructions on the BCBSTX Provider website at bcbstx.com/provider. The information is located under the **Education & Reference** tab/ **Forms** section.

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Refund Letters – Identifying Reason for Refund

The **Plan's** refund request letters include information about the specific reason for the refund request, as follows:

- The services rendered require *Prior Authorization/Referral*; none was obtained.
- Your claim was processed with an *incorrect Copay/Coinsurance or Deductible.*
- Your claim was received after the timely filing period; *proof of timely filing needed.*
- Your claim was processed with the *incorrect fee schedule/allowed amount.*
- Your claim should be submitted to the *member's IPA or Medical Group.*
- Your claim was processed with the *incorrect anesthesia time/minutes.*
- Your claim was processed with in-network benefits; however, it should have been processed with *out-of-network benefits.*
- Total charges processed exceeded the amount billed.
- Per the Member/Provider this claim was submitted in error.
- *Medicare should be primary* due to ESRD. Please file with Medicare and forward the EOMB to BlueCross and BlueShield.
- The patient has *exceeded the age limit* and is not eligible for services rendered.
- The patient listed on this claim is *not covered under the referenced policy.*
- The dependent was *not a full-time student* when services were rendered; benefits are not available.
- The claim was processed with *incorrect membership information.*
- The services were performed by the anesthesiologist; however, they were *paid at the surgeon's benefit level.*
- The services were performed by the assistant surgeon; however, they were *paid at the surgeon's benefit level.*
- The services were performed by the co-surgeon; however, they were *paid at the surgeon's benefit level.*
- The service rendered was considered a *bilateral procedure*; separate procedure not allowed.
- Claims submitted for rental; *DME has exceeded purchase price.*
- Overpayment was identified, as another insurance carrier is the primary for this patient. HCSC is the secondary carrier, but paid primary in error.

* **Note:** The refund request letter may be sent at a later date when the claim relates to **Blue Essentials and Blue Advantage HMO** accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:

- Self-funded ERISA (Employee Retirement Income Security Act)
- Indemnity Plans
- Medicaid, Medicare and Medicare Supplement
- Federal Employees Health Benefit Plan
- Self-funded governmental, school and church health plans
- Out-of-state Blue Cross and Blue Shield plans (BlueCard)
- Out-of-network (non-participating) providers

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Provider Refund Form (Sample)

Please submit refunds to: Blue Cross and Blue Shield of Texas, PO Box 731431, Dallas, TX 75373-1431

Provider Information:			
Name:			
Address:			
Contact Name:			
Phone Number:			
NPI Number:			

Refund Information				
1	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			

Refund Information				
2	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			

Refund Information				
3	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			

Refund Information				
4	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			

Refund Information				
5	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCM #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT
	REASON/REMARKS			

SIGNATURE	DATE	CHECK NUMBER	CHECK DATE

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Filing Claims - Claim Review

Provider Refund Form Instructions
Refunds Due to Blue Cross and Blue Shield of Texas

1. Key Points to check when completing this form:

a) Group/Member Number: Indicate the number exactly as they appear on the PCS (Provider Claim Summary) – including group and member's identification number

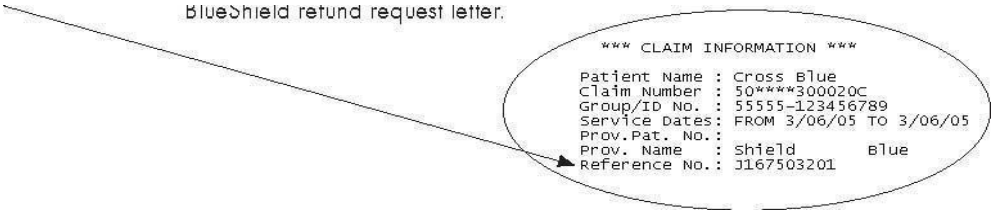
b) Admission Date: Indicate the admission or outpatient service date as MMDDYY entry.

c) BCBS Claim/DCN #: Indicate the BlueCross BlueShield Claim/DCN number as it appears on the PCS/EOB.

Please do not use your provider patient number in this field.

d) Provider Patient #: Indicate the Patient account number assigned by your office.

e) Letter Reference #: **If applicable**, indicate the RFCR letter reference number located in the BlueCross BlueShield refund request letter.



f) Check Number and Date: Indicate the check number and date you are remitting for this refund.

g) Amount: Enter the total amount refunded to BlueCross Blue Shield.

h) Remarks/Reason: Indicate the reason as follows:

- "C.O.B. Credit" — Payment has been received under two different Blue Cross memberships or from Blue Cross and another carrier. Indicate name, address, and amount paid by other carrier.
- "Overpayment" — Blue Cross payment in excess of amount billed; provider has posted a credit for supplies or services not rendered; provider cancelled charge for any reason; or claim incorrectly paid per contract.
- "Duplicate Payment" — A duplicate payment has been received from BlueCross for one instance of service (e.g. same group and member number).
- "Not our Patient" — Payment has been received for a patient that did not receive services at this facility/treatment center.
- "Medicare Eligible Duplicate Payment" — Payment for the same service has been received from Blue Cross and the Medicare intermediary.
- "Workers Compensation" — Payment for the same service has been received from Blue Cross and a Workers' Compensation carrier.

2. Mail the refund form along with your check to:

Blue Cross and Blue Shield of Texas
Refund and Recovery - Dept. 0695
P.O. Box 120695
Dallas, TX 75312-0695

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Electronic Refund Management (eRM)

eRM is on-line refund management tool which will help simplify overpayment reconciliation and related processes. The eRM application is available at **no additional charge**.

Enjoy **single sign-on** through Availity® *(Note: You must be a registered user with Availity to take advantage of eRM.)*

To register:

- **Visit the** Availity website at availity.com
- Receive **electronic notifications of overpayments** to help reduce record maintenance costs.
- **View overpayment requests** – search/filter by type of request, get more details and obtain real-time transaction history for each request.
- **Settle your overpayment requests** – Have BCBSTX deduct the dollars from a future claim payment. Details will appear on your PCS or EPS; information in your eRM transaction history can also assist with recoupment reconciliations.
- **Pay by check** – You will use eRM to generate a remittance form showing your refund details. One or multiple requests may be refunded to BCBSTX check number(s) will show on-line.
- **Submit unsolicited refunds** – If you identify a credit balance, you can elect to submit it on-line and refund your payment to BCBS by check, or have the refund deducted from a future claim payment.
- Stay aware with system **Alerts** – You will receive notification in certain situations, such as if BCBSTX has responded to your inquiry or if a claim check has been stopped.

How to Gain Access to eRM Availity Users

Click on the *HCSC Refund Management* link under the "Claims Management" tab. If you are unable to access this link, please contact your Primary Access Administrator (PAA). If you do not know who your Primary Access Administrator is, click on *Who controls my access?* Contact Availity Client Services at **1-800-AVAILITY (1-800-282-4548)** or visit the Availity website for more information or assistance.

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