

## Blue Choice PPO<sup>SM</sup> and Blue High Performance Network<sup>®</sup> (BlueHPN)<sup>®</sup> Provider Manual - Filing Claims – Claim Review Process

**Important note:**

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "Plan" is referenced, the information will apply to all PPO products.

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## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

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### Claim Review Process Overview

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

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### Claim Review Process

Claim Review Process is available to physicians or professional providers as described below.

- **Claim Reconsideration Requests**

Claim reconsideration requests are submitted electronically for review and/or reevaluation of situational finalized claim denials online (including BlueCard® out-of-area claims). This method of inquiry submission is preferred over faxed/mailed claim disputes, as it allows you to upload supporting documentation and monitor the status via Availity® Essentials.

For more details, refer to the [Claim Reconsideration Requests](#) page and instructional user guide in the **Provider Tools** section of our website.

- **Claim Review Form**

To request a claim review by mail, complete the [Claim Review Form](#) which can be found on the [BCBSTX website](#) under **Education & Reference** then [Forms](#). Include the following:

- Reason for claim review request – use the Claim Review Form and [Ineligible Reason Code List](#) to determine if your claim meets eligibility requirements for review.
- Be as specific as possible in detailing your request for review.
- It is necessary to provide all required data elements and use the proper form or your review will be rejected.

- **Electronic Refund Management (eRM)**

**eRM** is an on-line refund management tool for overpayment reconciliation and related processes. See more information on [eRM](#) further in this section F.

### Submission of Additional Information

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 supporting medical documentation specific to the claim denial and the reason for review, remember to submit only the medical records needed to support the review (HIPAA - minimum necessary).

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## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

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### Claim Review Process, cont.

The following are examples of what is not considered eligible under this review process (not an all-inclusive list):

- Membership denials, claim corrections, request for Medicare or Other Carrier paid amounts, these should be submitted electronically as a corrected claim.
- Denials related to non-covered benefits – these will not be reviewed for medical necessity – they are non-covered services under the member's benefit plan.
- Claim status questions regarding a pending claim or pending adjustment.

To submit **additional information** due to receiving a letter requesting information from BCBSTX, 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](http://bcbstx.com/provider) website.

Examples of requested information (not all inclusive):

- Medical records, progress reports, Operative report, diagnostic test results, history and physical exam, discharge summary, itemized bills

Examples of when to file **Corrected Claim** (non all inclusive):

- Any change to the claim, Explanation of Medicare Benefit, Other insurance payment information, any claim previously denied for missing information.

**Please file electronically when possible.**

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### Proof of Timely Filing

For those claims which are being reviewed for timely filing, BCBSTX 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.
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## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

### Types of Disputes & Timeframe for Request

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

DISPUTE TYPE	TIMEFRAME FOR REQUEST
AUDITED PAYMENT	Within <b>45</b> days following the receipt of written notice of request for refund due to an audited payment
OVERPAYMENT	Within <b>45</b> days following the receipt of written notice of request for refund due to overpayment
CLAIM DISPUTE	Within <b>180</b> days following the date of the BCBSTX Provider Claims Summary (PCS) for the claim in dispute

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

- If your claim has been maintained after review, you will receive a written notification of the claim review determination.
- If your claim has been overturned after reviewing your payment/ PCS will serve as your notification.

If the claim review determination is not satisfactory to you, you may request a 2<sup>nd</sup> claim review.

- The **Plans** will complete the 2nd claim review within **45** days following the receipt of your request for a 2nd claim review.
  - If your claim has been maintained after review, you will receive a written notification of the claim review determination
  - If your claim has been overturned after reviewing, your payment/ PCS will serve as your notification.
  - 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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## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

### Recoupment Process

The "Refund Policy for **Plans** " states that BCBSTX 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 **Blue Choice PPO and BlueHPN** 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](#)" within Section F (h) in this provider manual.

In some unique circumstances a health care provider may request, in writing, that BCBSTX review all claims processed during a specified period; in this instance, all underpayments and overpayments will be addressed on a claim-by-claim basis.

**\*Note** - The refund request letter may be sent at a later date when the claim relates to BCBSTX 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
- Overpayments due to settlement or finding of medical malpractice or negligence that does not occur within the 180 days.

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 PCS to the health care provider (Recoupment Process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable **Blue Choice PPO** claim(s).

To view an example of a recoupment, please refer to the sample PCS below.

For additional information or if you have questions regarding the **Blue Choice PPO** Recoupment Process, please contact **1-800-451-0287** to speak with a BCBSTX Customer Advocate.



# Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process Sample PCS Recoupment

DATE:	MM/DD/YY	1 2 3 4
PROVIDER NUMBER:	0001112222	
CHECK NUMBER:	123456789	
TAX IDENTIFICATION NUMBER:	987654321	

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

ANY MESSAGES WILL APPEAR ON PAGE 1

<b>6</b> PATIENT:	JOHN DOE	<b>9</b> IDENTIFICATION NO:	P06666-XOC123456789
<b>7</b> PERF PRV:	1234567890	<b>10</b> PATIENT NO:	12345KB
<b>8</b> CLAIM NO:	00001234567890C		

<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>
FROM/TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/ OTHER INELIGIBLE	AMOUNT PAID
02/09 – 02/09/12	03	PPO	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\*\*\*

<b>21</b> TOTAL SERVICES NOT COVERED:	25.48
<b>22</b> PATIENT'S SHARE:	0.00

**23** PROVIDER CLAIMS AMOUNT SUMMARY

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	<b>RECOUPMENT AMOUNT:</b>	<b>\$31.52</b>
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.



## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

### Professional Provider Claim Summary Field Explanations

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



## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

### Refund Policy

BCBSTX under its **Blue Choice PPO** plan strives to pay claims accurately the first time; however, when payment errors occur, BCBSTX needs your cooperation in correcting the error and recovering any overpayment.

#### When a Health Care Provider Identifies an Overpayment:

- 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](#) - located further in this Section F

#### When BCBSTX Identifies an Overpayment:

If BCBSTX 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. If BCBSTX 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 BCBSTX by submitting via eRM or a Claim Review Form in accordance with the Claim Review Process. In determining whether this deadline has been met, BCBSTX will presume that the refund request letter was received on the 5<sup>th</sup> business day following the date of the letter.
- If BCBSTX does not receive payment in full within the Overpayment Review Deadline, we will recover the overpayment by offsetting current claims reimbursement by the amount due BCBSTX (refer to Recoupment Process below) 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 eRM request or Claim Review Form within the Overpayment Review Deadline.
- For information concerning the Recoupment Process, please refer to the "[Recoupment Process](#)" listed earlier in this Section F (h) of the *Blue Choice PPO - Provider Manual*.

**Note:** In some unique circumstances a health care provider may request, in writing, that BCBSTX review all claims processed during a specified period; in this instance, all underpayments and overpayments will be addressed on a claim-by-claim basis.

For additional information or if you have questions regarding the BCBSTX **Blue Choice PPO** Refund Policy, please contact **800-451-0287** to speak with a BCBSTX Customer Advocate. If you want to request a review of the overpayment decision, please view the [Claim Review Process](#) earlier in this Section F of the *Blue Choice PPO – Provider Manual*. You can also locate the [Claim Review Form](#) on the [BCBSTX provider website](#). The information is located in **Forms** under **Education & Reference Center** section.



## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

### Refund Letters – Identifying Reason for Refund

BCBSTX's refund request letters under its **Blue Choice PPO** plan include information about the specific reason for the refund request, as follows:

- Your claim should have been authorized and processed by Carelon Medical Benefits Management.
- 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 End Stage Renal Disease (ESRD). Please file with Medicare and forward the Explanation of Medicare Benefits (EOMB) to BCBSTX.
- 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*.
- The overpayment was identified as another insurance carrier is the primary for this patient. BCBSTX is the secondary carrier, but paid primary in error.

**Note:** The refund request letter may be sent later when the claim relates to BCBSTX 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
- Out-of-state provider claims including Away from Home Care



# Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process Provider Refund Form (Sample)

Please submit refunds to Blue Cross and Blue Shield of Texas, Dept. 0695, P.O. Box 120695, Dallas, TX 75312-0695

### Provider Information:

Name:			
Address:			
Contact Name:			
Phone Number:			
NPI Number:			

### Refund Information:

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

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

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

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

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

6	GROUP # FROM PCS	MEMBER I.D. FROM PCS	ADM DATE	CLAIM/DCN #
	PATIENT'S NAME	PROVIDER PATIENT #	LETTER REFERENCE #	REFUND AMOUNT:
	REASON/REMARKS			

SIGNATURE	DATE	CHECK NUMBER	CHECK DATE
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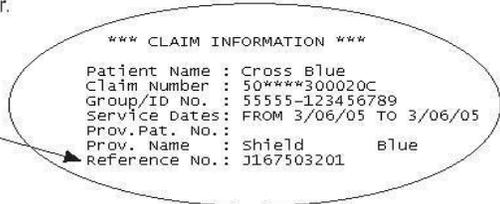


# Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process Provider Refund Form Instructions Refunds Due to Blue Cross and Blue Shield of Texas

## 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 the amount paid by the other carrier.
  - “Overpayment” Blue Cross payment in excess of the amount billed; provider has posted a credit for supplies or services not rendered; provider canceled 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

## Blue Choice PPO and BlueHPN Provider Manual - Filing Claims – Claim Review Process

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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 Essentials. (Note: You must be a registered user with Availity to take advantage of eRM.)

- **Visit** the Availity Essentials website.
- **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.

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### How to Access eRM via Availity

Once you are registered with Availity:

- Log into [Availity Essentials](#)
- Select **Payer Spaces** from the navigation menu and choose **BCBSTX**
- Select the **Applications** tab, then choose **Refund Management - eRM\***

\*New users will be prompted to complete the one-time eRM onboarding form and email verification to gain access to the eRM system.

If you are unable to access eRM from the BCBSTX-branded Payer Spaces, contact your Availity Administrator. To identify your Availity Administrator(s), select My Account under My Account Dashboard on the Availity homepage. You may also contact Availity Client Services at **1-800-282-4548** or visit the [Availity](#) website for more information or assistance.

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