

8 – Claims Submission

Overview

Introduction This section describes both hard-copy and electronic claims submission processes. For those provider offices that are not submitting claims electronically, we encourage you to consider this faster, easier, and more accurate method for claims submission. We would be happy to help you make this transition. See [Section 9 – eCommerce Tools](#) for more information.

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8.1 Contacts

Contact List The table below includes contact information for claims filing questions, electronic claims filing, and accessing eligibility and benefit information.

For...	Contact	Phone #	Internet
Claims questions – initial contact	Provider Service Unit	1-888-349-3706	
Electronic claims filing	Availity	1-800-282-4548	www.availity.com
	Electronic Commerce Center	1-800-746-4614	
Eligibility and benefits	Availity	1-800-282-4548	www.availity.com
	Interactive Voice Response (IVR)/ Provider Service Unit (claims questions)	1-888-349-3706	

8.2 Claims Submission Requirements

Claim Requirements

Submit claims within 180 days of the date of service. **Claims submitted beyond this time frame will be denied.** See more about [Timely Filing](#) in this section. Each claim submitted must be for a single patient with services performed by one provider. Please do not include multiple patients or services by more than one provider on one claim form.

Accurate, complete claims are processed more quickly than claims that need research. If we are not able to complete processing because information is missing or unclear, your claims will be returned for the required information. When a claim is returned, please provide the missing or corrected information and return the claim for processing within 30 days.

Claim Forms

Submit encounters and claims using the appropriate claim form: CMS-1500 (version 08/05) form for professional claims; UB-04 (CMS-1450) form for facility claims. Submit encounter and claim information according to the instructions.

Samples of the CMS-1500 claim form and the UB-04 are included at the end of this section under [Attachments](#). For detailed instructions on proper completion of these forms, please visit our website at bcbsnm.com (select *Providers, Claims & Eligibility*, and then [Submitting Claims](#)).

Splitting Charges on Claims

In general, all services provided on the same day should be billed under one electronic submission or when required to bill on paper, utilize one CMS-1500 claim form when possible. When more than six services are provided, multiple CMS-1500 claim forms may be necessary.

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8.2 Claims Submission Requirements, Continued

Procedure Codes

Use the American Medical Association Current Procedural Terminology (CPT[®]) or the Healthcare Common Procedure Coding System (HCPCS) codes, including appropriate modifiers, for professional claims and revenue codes for hospital claims. **Providers must bill with current codes.** Codes marked as *deleted* in any version of the CPT or HCPCS will not be accepted after the codes' effective date for deletion. Consistent with Medicare policy, there will be no "grace period" for recognizing deleted codes. HIPAA regulations require the use of valid, nationally recognized codes. Claims that use deleted codes after the codes' effective date of deletion will be denied and returned to the provider for resubmission with current, valid codes. When billing for services provided, codes should be selected that best represent the services furnished.

When you bill with a miscellaneous procedure code or a code that is used for a service that is not described in CPT, submit a clear description of the service or supply and supporting documentation with the claim.

Commonly missed information includes:

- Group number
 - National Provider Identifier (NPI)
 - Patient's date of birth
 - Diagnosis
 - Admission/discharge date
 - Initial date of treatment
-

8.3 National Provider Identifier (NPI)

Using NPI Numbers

Effective May 23, 2008, the National Provider Identifier (NPI), mandated by HIPAA regulations, became the single provider identifier that must be used by health plans for all standard electronic claim transactions.

Refer to National Plan and Provider Enumeration System (NPPES) to obtain an NPI.

An individual (type 1 NPI) for the rendering provider is required on all professional claims. An organization (type 2 NPI) is required for all billing entities (medical groups, incorporated practices, facilities, durable medical equipment (DME) suppliers, etc).

Each DME supplier location out of which they are providing equipment is required to have a separate NPI per Health Insurance Portability and Accountability Act (HIPAA) regulations.

Note: BCBSNM requires NPIs on electronic **and** paper claims.

If you have questions, you may contact your [Network Services Provider Representative](#).

Additional information regarding NPI can be found on the following websites:

- Centers for Medicare and Medicaid Services (CMS):
cms.hhs.gov/NationalProvidentStand/
 - National Plan and Provider Enumeration System (NPPES):
nppes.cms.hhs.gov
-

8.4 Submitting Claims

Electronic Claims Submission

BCBSNM strongly encourages the electronic submission of claims. Claims may be submitted electronically 24 hours a day, seven days a week. All BCBSNM facility (UB-04) and professional (CMS-1500) claims (excluding adjustments) can be filed electronically at no charge through the Availity[®] Health Information Network.

For more information about submitting claims electronically, refer to [Section 9, e-Commerce Tools](#).

Paper Claims Submission

Submit encounters and claims following the instructions given in [Section 8.2](#), and mail to:

Blue Cross and Blue Shield of New Mexico
P.O. Box 27630
Albuquerque, NM 87125-7630

BlueCard Program Claim Filing

For out-of-state claims filing, refer to [The BlueCard Program Provider Manual](#). The full manual is included as an attachment in Section 20, **Attachments**.

8.5 Corrected Claims

Corrected Claims

Corrected claims must be submitted within 180 calendar days of the date of service.

CMS-1500 corrected claims may be submitted electronically by using the [Claim Inquiry Resolution \(CIR\) tool](#). If you must file CMS-1500 corrections on paper, complete the [Claim Review Form](#) and attach the form to the top of the claim. Mail the form and the corrected claim to the address indicated on the form.

Claims that are submitted with a “corrected claim” stamp or notation are not recognized by our system and could delay the processing of your corrected claim. Refer to [Section 8.7](#) for Timely Filing requirements.

UB-04 corrected claims should be submitted electronically whenever possible, using the appropriate Type of Bill indicating a corrected claim (e.g., 117 vs. 111). If you must file the UB-04 corrections on paper, please attach the [Claim Review Form](#) following the same instructions above as for the CMS-1500 claims.

When filing corrected claims on services for Medicare primary members, the corrected claims should be filed directly with Medicare, not BCBSNM. Filing the corrected claims with BCBSNM may cause a delay in processing or result in a denial stating either the claim must be filed with Medicare or the claim is a duplicate. Providers should follow the same process for filing corrected claims for Medicare-primary members just as if they were filing the claim for the first time with Medicare.

8.6 Recoupment Process

8.6.1 Paper Refund Requests

When an overpayment on a claim has occurred, BCBSNM will initiate a refund request, providing physicians, facilities, and practitioners with at least 30 days written notice, explaining the reason for the overpayment, before engaging in additional overpayment recovery efforts. A remittance form and postage-paid envelope are also enclosed for your convenience should you prefer to submit a refund check. However, if you do not respond to us in writing or by phone within 30 days, the overpayment will be eligible for collection by auto-recoupment. If a provider requests an appeal within 30 days of receipt of a request for repayment of an overpayment, BCBSNM will not require repayment of the alleged overpayment before the appeal is concluded.

The recoupment message that appears on the Provider Claim Summary (PCS) will show the patient name, patient account number (if available), BCBSNM group and member number, overpaid claim number, the dates of service, the amount taken toward the overpayment, and an abbreviated overpayment reason. It may be necessary to offset an overpayment from multiple checks. Due to system constraints, checks will always show a balance of \$50 remaining, and the claims summary will only reflect the collection being taken on the check; it will not reflect the entire negative balance owed by the provider. Please save your recoupment letters to assist you in balancing your payments. Overpayments can be returned to:

Blue Cross and Blue Shield of New Mexico
Attention: Collections Department
P.O. Box 27630
Albuquerque, NM 87125-7630

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8.6 Recoupment Process, Continued

8.6.2 Electronic Refund Management

Electronic Refund Management (eRM) is an online tool that can help simplify your overpayment reconciliation and related processes, and is available at no additional charge.

In addition to single sign-on convenience, eRM enables you to:

- Receive electronic notification of overpayments
- View overpayment requests
- Inquire/dispute/appeal a request
- Deduct from future payments
- ... and more!

To find out more, visit our website under [Education & Reference/Tools](#) for webinar dates.

Note: You must be a registered user with Availity® to take advantage of ERM. To register, visit the [Availity website](#) at www.availity.com/providers/registration-details/

8.7 Timely Filing

Overview

The BCBSNM contract requires providers to initially submit accurate, complete claims **within 180 days** of the date of service; see contract page 4, Article IIB.3. If an original claim is submitted **after the 180-day limit**, it is **denied** for timely filing.

Claims appeals must be submitted within 90 days of the Remittance Advice/Provider Claim Summary. Submit appeals along with the [Claim Review Form](#). Refer to [Section 15.1.2 Appeals](#)

Proof of Timely Filing

Claims submitted along with **proof** of initial timely filing, which are within 180 days of the date of service, will be allowed. Claims received for timely filing reconsideration that are more than 180 days from date of service will be denied.

Claims submitted for consideration of timely filing must be reviewed with information that indicates the claim was initially submitted within the appropriate time frame. **Acceptable proof** of claim filing within 180 days of the date on which service was rendered includes the following situations or documentation:

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8.7 Timely Filing, Continued

Proof	Examples
<p><u>Paper Filer:</u></p> <p>Printout indicating the original date the claim was submitted and to whom</p>	<ul style="list-style-type: none"> • Account ledger posting that includes multiple patient submissions • Patient ledger • BCBSNM returned claim sheet • UB-04 with date of original submission in box 86
<p><u>Electronic Filer:</u></p> <p>Copy of BCBSNM or provider's clearinghouse confirmation report with patient detail</p>	<ul style="list-style-type: none"> • EMC Input Transaction Report • Blue Cross Data Collection – BCBSNM • Accepted Claims Report <p>Note: A BCBSNM rejection report or a report from the provider's clearinghouse without patient detail is not acceptable proof.</p>
<p>Coordination of Benefits (COB) information within 180 days from other insurance or Medicare processing date</p>	<ul style="list-style-type: none"> • Medicare EOB • Other insurance EOB or EOP
<p>Proof of follow-up with member for lack of insurance information</p> <p>Note: Member is responsible for providing current and appropriate insurance information to the provider</p>	<ul style="list-style-type: none"> • Copies of dated letters requesting information from member
<p>Document indicating claim sent to wrong carrier within 180 days from date of service and received by BCBSNM within one year of service date</p>	<ul style="list-style-type: none"> • Copy of EOB from other insurance carrier showing denial
<p>Enrollment issues are reviewed on a case-by-case basis</p>	<ul style="list-style-type: none"> • Member not enrolled, claim returned to provider
<p>Third-party liability issues are reviewed on a case-by-case basis</p>	<ul style="list-style-type: none"> • Additional information will be requested from the member and/or provider of services
<p>Legal incapacity issues are reviewed on a case-by-case basis</p>	<ul style="list-style-type: none"> • Physical illness • Mental condition • Death of contract holder • Death of provider

8.8 Eligibility and Benefits

Overview	Providers have three ways to determine eligibility and benefits for our Members. Availity, LLC provides eligibility, benefit, and claims information through their web portal which is free to registered providers. Providers may also use the Interactive Voice Response System (IVR) or HealthXnet.
8.8.1 Interactive Voice Response (IVR) System	To make it easier for our providers to find information on benefits, eligibility, and claims, we have an interactive voice response system. This self-service system allows our speech recognition technology to respond when the provider speaks, which saves administrative time. Refer to Section 9, eCommerce Tools for more about the IVR System.
8.8.2 Availity	Availity is a HIPPA compliant, nationwide, all-payer clearinghouse and Health Information Network that uses the Internet to exchange information in real time between health care providers, payers, and other health care stakeholders. Availity also supports batch transactions. For more information, refer to Section 9, e-Commerce Tools .
8.8.3 HealthXnet	HealthXnet allows you to check member eligibility, benefits, and claims information for a large cross-section of payers. As with all the e-Business tools, HealthXnet gives you the online advantages of convenience, efficiency and cost savings so your time can be better spent with your patients. For more information, call 866-676-0290 or visit HealthXnet online at www.healthxnet.com

8.9 Dental Related Medical Claims

Covered Medical Services

Standard covered medical services **may** include surgeon's charges for the following (please check the individual group plan or contact customer service for a complete list as covered services may vary):

- medically necessary orthognathic surgery
 - external or intraoral cutting and draining of cellulitis (not including treatment of dental-related abscesses)
 - incision of accessory sinuses, salivary glands, or ducts
 - lingual frenectomy
 - removal or biopsy of tumors or cysts of the jaws, cheeks, lips, tongue, roof, and floor of mouth when pathological examination is required
 - **some plans cover** dental services that may be related to, or required as the result of, a medical condition or procedure (e.g., chemotherapy or radiation therapy)
 - **most plans cover** standard diagnostic, therapeutic, surgical, and nonsurgical treatments of temporomandibular joint (TMJ) and craniomandibular joint (CMJ) disorders or accidental injuries
-

Coding

To avoid delays in claim processing, please follow these tips:

- Claims may be submitted on a dental claim form, but should include a diagnosis code(s).
 - If billing with medical code 41899, include a complete description of the dental procedure rendered, tooth number, or area of the mouth.
 - If services are accident related, include the date and details of the accident, tooth number or area of the mouth.
 - Prior approval should be requested for accident related services (except if emergency treatment was rendered within 48 hours of the accident).
 - Refer to [Section 10, Preauthorization](#) for more information about prior approval for oral surgery, hospital services, etc.
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8.10 Injury-Related Claims

Injury-Related Claims Claims received with one of the following injury-related diagnoses are processed in the usual manner, and a letter requesting more information is sent to the member. To expedite processing, please include information regarding how, when, and where the injury occurred.

ICD-9 Code	Diagnosis
005 - 0059	Other food poisoning (bacterial)
344 - 3449	Other paralytic syndromes
353 - 3559	Nerve root and plexus disorders
451 - 4519	Phlebitis and thrombophlebitis
500 - 505	Pneumoconiosis and other lung diseases due to external agents
506 - 5069	Respiratory conditions due to chemical fumes and vapors
508 - 5089	Respiratory conditions due to other and unspecified external agents
512 - 5128	Pneumothorax
550 - 5509	Inguinal hernia
551 - 55329	Other hernia of abdominal cavity
5538 - 5539	Hernia of other specified sites
717 - 7179	Internal derangement of knee
718 - 7189	Other derangement of joint
719 - 7199	Other and unspecified disorders of joint
722 - 7229	Intervertebral disc disorders
723 - 7239	Other disorders of cervical region
724 - 7249	Other and unspecified disorders of back
726 - 7269	Peripheral enthesopathies and allied syndromes
727 - 7279	Other disorders of synovium, tendon, and bursa
728 - 7283	Disorders of muscle, ligament, and fascia
7289 - 729	Unspecified disorder of muscle, ligament, and fascia
800 - 9579	Injury, trauma, and poisoning
9583 - 9599	Certain Traumatic Complications and Unspecified Injuries
992 - 9950	Effects of heat and light
996 - 99679	Complications peculiar to certain specified procedures
9969 - 99699	Complications of reattached extremity or body part
998 - 9984	Other complications of procedures, not elsewhere classified
E800 - E8499	Railway accident involving collision
E866 - E8699	Accidental poisoning by other and unspecified solid and liquid substances

8.11 End Stage Renal Disease and Medicare

ESRD Eligibility and Coordination

End-stage renal disease (ESRD) patients may be eligible for Medicare regardless of age, the number of employees, or the employment status (e.g., retired).

If the member's group health plan is primary because of disability, age, or another reason than ESRD, then the group coverage will continue to pay as primary during the first 30-month (for home dialysis) or 33-month (for center dialysis) coordination period from the first date of dialysis. Once the coordination period has been completed, Medicare becomes primary. If Medicare has been deemed primary because of disability, age, etc., and *then* the member develops ESRD, Medicare will remain primary and the ESRD guidelines will not be applicable. Medicare remains primary in this situation only.

In addition, if a kidney transplant occurs during the coordination period, the group health plan will continue to pay as primary until the 30 or 33 months have been completed. Once the coordination period has been completed and Medicare becomes primary and a transplant occurs during this time, Medicare will remain primary for 36 months from the transplant date. If the transplant is a success after the 36 months, the group health plan would again become primary.

BCBSNM will identify members with ESRD and store their Medicare coverage information. It is the provider's responsibility to keep track of the coordination period.

8.12 Coordination of Benefits (COB)

COB Calculation When BCBSNM is the secondary insurance carrier, the calculation of the secondary payment is based on the provider's contractual arrangements with BCBSNM using the maximum allowable fee. The payment from the primary insurer is used first to offset the member's copayment, coinsurance, or deductible. [Coordination of Benefits Form](#)

Order of Benefit Determination To determine the order of benefits, use the first of the following rules that apply:

Rule	Example
<p>1. Non-Dependent or Dependent The plan that covers the person as an employee, member, subscriber, or retiree (other than as a dependent) is primary and the plan that covers the person as a dependent is secondary.</p>	<p>Jim and Laurie are married and each carries a family policy through their employer. Jim's coverage will be primary for him and Laurie's coverage will be primary for her.</p>
<p>2a. Child Covered Under More Than One Plan – Birthday Rule The primary plan is the plan of the parent whose birthday is earlier in the year (refers to month and day, not year). This is true if:</p> <ul style="list-style-type: none"> • The parents are married • The parents are not separated (whether or not they ever have been married), or • A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage. 	<p>Josh and Amy are married and both carry family coverage. They have one child who is also covered under both policies. Josh's date of birth (DOB) is 01/15/74 and Amy's DOB is 03/11/75. Josh's coverage would be primary for their child because his birthday is the earliest.</p>
<p>2b. Child Covered Under More Than One Plan – Longer Length of Coverage If both parents have the same birthday, the plan that has covered either of the parents longer is primary.</p>	<p>Pat and Michael are married and both carry family coverage. They have one child who is also covered under both policies. Michael's date of birth is 01/26/69 and Pat's DOB is 01/26/73. Pat has had her coverage in force effective 01/01/90, and Michael's coverage has been in force effective 06/01/01. Pat's coverage will be primary for their child.</p>

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8.12 Coordination of Benefits (COB), Continued

Order of Benefit Determination (continued)

Rule	Example
<p>2c. Child covered Under More Than One Plan – Court Decree If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge.</p>	<p>Mike and Claire are divorced, and both carry family coverage for their two children. When they divorced, there was a court decree that indicated Mike was responsible for both children's health care coverage. Mike is required to provide health coverage for his two children. His coverage for them will be primary over any group health coverage provided by Claire.</p>
<p>2d. Child Covered Under More Than One Plan – Custodial Parent If the parents are not married or are separated (whether or not they ever were married) or are divorced, and there is no court decree allocating responsibility for the child's healthcare services or expenses, the order of benefit determination among the plans of the parents and the parent's spouses (if any) is: (i) The plan of the custodial parent; (ii) The plan of the spouse of the custodial parent; (iii) The plan of the non-custodial parent; and then (iv) The plan of the spouse of the non-custodial parent.</p>	<p>John and Rose were never married, and no longer live together. They had one child who now lives with Rose. Both parents carry family coverage for their child. There is no divorce or court decree allocating responsibility. The child lives with her mother, and as a result, Rose is the custodial parent. Rose's insurance would be primary.</p>
<p>3. Active or Inactive Employee The plan that covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) is primary. If the other plan does not have this rule; and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.</p>	<p>John took early retirement from his job, and as part of his retirement benefit, he continued to carry their group health insurance. He is now working for another company that also provides group health insurance. (No Medicare involvement) John's new coverage through his active employment will be primary over his coverage as a retiree.</p>

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8.12 Coordination of Benefits (COB), Continued

Order of Benefit Determination (continued)

Rule	Example
<p>4. Continuation Coverage If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. These guidelines also apply when Medicare is the other insurance (except when End Stage Renal Disease is involved). If the other plan does not have the Continuation of Coverage rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.</p>	<p>Debra ended her employment with her company and elected to continue her health coverage by applying under COBRA. She has now started a new job that also provides group health coverage. Debra's new coverage through her active employment will be primary over her continuation coverage.</p>
<p>5. Longer or Shorter Length of Coverage If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.</p>	<p>Kelly has two different employers and maintains full health care coverage with both. Plan A was effective 01/01/01 and Plan B was effective 01/01/03. As both coverage's are received because of active employment by Kelly, the one covering her the longest (Plan A) will be primary.</p>
<p>6. None of the Preceding Rules Apply If none of the preceding rules determines the primary plan, the allowable expenses shall be shared equally between the plans.</p>	<p>--</p>

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8.12 Coordination of Benefits (COB), Continued

Subrogation (Third Party Liability)

Subrogation occurs when one party is injured as a result of the actions or negligence of another (e.g., slip and fall accidents, assault, auto accident, etc). BCBSNM has the right to reimbursement for all benefits provided from the third party for those expenses. If the insured does not file a claim, the insurer can still recover directly from the liable party.

Example: John Doe has health insurance with BCBSNM. John was at a family dinner and slipped on his cousin's front steps breaking his ankle. The carrier paid for the related medical expenses totaling \$3,000. John's cousin had liability coverage through her homeowner's insurance. However, John did not want to file a claim against his cousin's policy and was satisfied with the carrier's payments. However, BCBSNM was entitled to file a claim to recover from the cousin's homeowner's insurance which was liable for the related treatment and filed a claim in order to seek recovery of the \$3,000.

Subrogation recoveries may not be claimed by a participating physician or other health care provider in lieu of, or in addition to, making a claim for payment pursuant to the terms and provisions of your Agreement when a member has BCBSNM insurance. To do so constitutes balance billing, which is a breach of contract for participating physicians and providers.

8.13 Bundling Logic

Overview BCBSNM utilizes McKesson's ClaimsXten™ software editing program to assist in the process of provider claim reimbursement decisions. The software was implemented on February 28, 2011 which replaced ClaimCheck®. ClaimsXten uses the coding criteria and guidelines of HCPCS and CPT, RBRVS Relative Value Units, and the practice standards of most physicians to determine appropriately billed procedures and services on claim submissions. ClaimsXten edits are supported by clinical studies published in professional journals or approved by national professional organizations.

Using ClaimsXten does not reflect a change in BCBSNM's payment policies. This software enables us to process your claims with less manual intervention, achieving a greater degree of efficiency and consistency.

ClaimsXten edits do not mirror those of the National Corrective Coding Initiative (NCCI), although they are often similar. Modifiers sometimes, but not always, alter the results of bundling based on the specific procedure codes and modifiers used in a particular claim scenario. Clear Claim Connection (C3) can be used to determine the result of ClaimsXten bundling edits for specific procedure code combinations. See more about C3 in [Section 8.14](#).

ClaimsXten specifically addresses three CPT billing practices, which are described below. Also refer to the [Tools section](#) on our website for more information on C3 and ClaimsXten.

Unbundling Multiple individual CPT codes used instead of a single, comprehensive global procedure code. For example:

Code	Narrative	Charge
80053	Comprehensive Metabolic Panel	\$190
84443	Assay Thyroid Stimulating Hormone	\$60
85025	Complete CBC w/Auto Differential WBC	\$52

Rebundles to 80050 General Health Panel. Charges will be aggregated and the appropriate allowance applied to billed codes.

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8.13 Bundling Logic, Continued

Incidental/ Inclusive Procedure

A procedure considered to be integral to another major, primary, or principle procedure. For example:

Code	Narrative	Charge
29888	Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction	\$2,200
29871	Arthroscopy, knee, surgical; for infection, lavage and drainage	\$1,350

Code 29871 is **incidental** to 29888. The reimbursement for 29871 will be rejected and the appropriate allowance applied to 29888, since 29871 is carried out at the time of the more complex, primary procedure and separate reimbursement is not warranted. It is often considered a usual and necessary part of the primary procedure, or is clinically integral to the performance of the primary procedure, unless performed in a separate compartment and a substantial, documented amount of time is involved in the separate procedure.

Mutually Exclusive Procedures

Those procedure codes that, by normal practice standards, would not be performed on an individual patient on the same day. For example:

Code	Narrative	Charge
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	\$3,600
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction	\$3,200

Procedure code 77003 is **mutually exclusive** to 64483. The charges will be aggregated and the appropriate allowance applied to 64483.

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8.13 Bundling Logic, Continued

Reconsideration Requests

If you have a question or dispute concerning a bundled or rejected charge that is related to a ClaimsXten edit determination, contact the Provider Service Unit (PSU) at BCBSNM within 180 days from the date of service at **1-888-349-3706**. Request a review or reconsideration of the claim decision. The PSU representative will initiate the request for your office and refer it to the Health Services Medical Review Unit for review. If your office has any supporting documentation that would assist us in the review of the charges, please fax or mail the information to the PSU service representative with whom you are working with so it can be included with your reconsideration request.

If the bundled or rejected charge decision is upheld, you will receive a letter of explanation from Health Services. If the bundled or rejected charge decision is overturned and will be allowed, the adjustment request will go back to the appropriate customer service department and you will be advised by phone or you will receive an adjusted PCS as notification that an adjustment has been completed.

8.14 Clear Claim Connection™

Overview Clear Claim Connection* (C3) is a Web-based code auditing reference tool that mirrors BCBSNM edits (i.e., unbundling, mutually exclusive, and incidental).

C3 is designed to make BCBSNM payment policies, rules, and edit rationale easily accessible for viewing via the website. C3 can increase your administrative efficiency by reducing manual inquiries, claims appeals, and misunderstandings regarding BCBSNM's edits.

Physicians and their office staff, registered with Availity, can review the claim payment methodology and reimbursement policies behind coding edits. While on the Availity website, look for the hyperlink **Claims Management/Research Procedure Code Edit**. Visit www.availity.com to sign up if you are not currently an Availity user.

*Clear Claim Connection, ClaimsXten and CodeReview are trademarks of McKesson Information Solutions, Inc., an independent contractor.

8.14.1 Modifiers

Modifiers are important for correct results during ClaimsXten editing. Modifiers sometimes, but not always, alter the results of bundling based on the specific procedure codes and modifiers used in a particular claim scenario. C3 can be used to determine the result of ClaimsXten bundling edits for specific procedure code combinations.

Modifiers 24, 25, 57, 59 each indicate extenuating circumstances that can alter bundling for some code pairs. Modifiers 50 and 51 for secondary and bilateral procedures can impact bundling. Modifiers LT, RT, and modifiers for indicating upper and lower eyelids and various digits of the hands and feet can also be important for correctly relaying information on services rendered, and the resulting edits. Refer to the list of modifiers as described in the CPT for more information on how each should be used. Correct use is critical to correct claims payment.

Whether the use of a modifier exempts the procedure code pairs from bundling depends on a variety of information, including the procedure code pairs submitted, the ClaimsXten editing logic for the procedure codes, and the modifier indicators on the NCCI data for the procedure codes. Providers can utilize the ClaimsXten online tool and C3 to determine the results of a particular scenario. The tool allows entry of up to four modifiers.

8.15 Provider Claim Summary (PCS)

Overview

The Provider Claim Summary (PCS) is a notification statement sent to providers after a claim has been processed. The content of each PCS may vary based on the member's benefit plan and the services provided.

Note: Electronic Payment Summaries (EPS) are available; see [Section 9](#), e-Business Tools.

The PCS includes:

- Patients 65 and older are noted (indicating Medigap)
- Combined reporting: multiple patients are listed on one PCS for ASO groups
- Multiple patient claims are listed on one summary for ASO groups
- Patient information
- Data elements specific to services rendered; e.g., Begin/End Dates, Procedure Code
- Informational messages
- The amount paid
- The amount of the bill that is the patient's share
- The amount of the bill that is the contractual allowance
- On facility forms, the DRG code is listed

The patient's share may include:

- Any portion of the billed amount that is not covered
- The patient's deductible/copayment amounts
- PPO program coinsurance

The sample PCSs on the following pages are only a **reference**. Your summary may be slightly different than the samples.

It is important to review your PCSs to ensure your records are current and accurate. To inquire about patient membership, benefits, and claim status information, call the Interactive Voice Response/Provider Service Unit at **1-888-349-3706**.

Continued on next page

8.15 Provider Claim Summary (PCS), Continued



PROFESSIONAL PROVIDER CLAIM SUMMARY

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, NM 60000

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	12	13	14	15	16	17	18	19
FROM/TO DATES	PS*	TS**	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/OTHER INELIGIBLE	AMOUNT PAID
02/09 – 02/09/10	03	006	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

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

PROVIDER CLAIMS AMOUNT SUMMARY

23

NUMBER OF CLAIMS:	1	AMOUNT PAID TO SUBSCRIBER:	\$0.00
AMOUNT BILLED:	\$76.00	AMOUNT PAID TO PROVIDER:	\$19.00
AMOUNT OVER MAXIMUM ALLOWANCE:	\$25.48	RECOUPMENT AMOUNT:	\$0.00
AMOUNT OF SERVICES NOT COVERED:	\$25.48	NET AMOUNT PAID TO PROVIDER:	\$11.00
AMOUNT PREVIOUSLY PAID:	\$0.00		

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

25 ** TYPE OF SERVICE (TS)
 006. MEDICAL.

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

FOR INQUIRIES RELATED TO GROUP NUMBER YIHOST, YIPPOX, OR YIPPOW, PLEASE CALL 1-800-222-7992.
 FOR ALL OTHER GROUP NUMBERS, CALL 1-888-349-3706.

Continued on next page

8.15 Provider Claim Summary (PCS), Continued

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 BCBSNM
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	TS	Type of service
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 BCBSNM 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	Type of Service (TS)	The description for the type of service code used in field 13
26	Messages	The description for messages relating to: non-covered services, program deductions, and PPO reductions

Note: Not all PCSs are the same; this PCS is provided as a sample.

Continued on next page

8.15 Provider Claim Summary (PCS), Continued



FACILITY PROVIDER CLAIM SUMMARY

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

5 **ABC MEDICAL GROUP**
123 MAIN STREET
ANYTOWN, NM 60000

ANY MESSAGES WILL APPEAR ON PAGE 1

*****OVER 65 OUT-PATIENT

6	PATIENT: JOHN DOE	PATIENT NO: 12345kb			
7	CLAIM NO: 00001234567890C	9	ADMIT DATE	FROM DATE	END DATE
8	GROUP-SUB NO: P06666-XOC123456789		00/00/00	01/06/10	01/14/10

10	11	12	13	14	15	16	17
DAYS/ TRT	DRG CODE	PROVIDER CHARGE	OTHER PAYABLE/ WITHHOLD	FACILITY ALLOWABLE	ADJUSTED PROV. CHARGE	MANAGED CARE DEDUCTION(S)	TOTAL AMOUNT PAID
00013		\$732.00	\$0.00	\$0.00	\$732.00	0.00	\$201.68

18 MEDICARE CROSSOVER CLAIM MESSAGES/REASONS: 0G

DEDUCTIONS/OTHER INELIGIBLE

19	PORTION ELIGIBLE FOR PAYMENT BY ANOTHER CARRIER/MEDICARE:	\$530.32
20	TOTAL DEDUCTIONS/OTHER INELIGIBLE:	\$530.32
21	PATIENT'S SHARE:	\$0.00

22 PROVIDER CLAIMS AMOUNT SUMMARY

NUMBER OF CLAIMS:	1	AMOUNT PAID:	\$201.68
PROVIDER CHARGES:	\$732.00	RECOUPMENT AMOUNT:	\$0.00
ADJUSTED PROVIDER CHARGES:	\$732.00	NET AMOUNT PAID:	\$201.68
PATIENT'S SHARE	\$0.00		

23 MESSAGES/REASONS:
 (0G). THE MEMBER/PATIENT MAY HAVE HEALTH COVERAGE THROUGH ANOTHER CARRIER/MEDICARE. EXPENSES MAY BE ELIGIBLE FOR PAYMENT BY THAT CARRIER.

FOR INQUIRIES RELATED TO GROUP NUMBER YIHOST, YIPPOX, OR YIPPOW, PLEASE CALL 1-800-222-7992.
 FOR ALL OTHER GROUP NUMBERS, CALL 1-888-349-3706.

Continued on next page

8.15 Provider Claim Summary (PCS), Continued

Facility Provider Claim Summary Field Explanations

1	Date	Date the summary was finalized
2	Provider Number	Provider identification number
3	Check Number	The number assigned to the check for this summary
4	Tax Identification Number	The number that identifies your taxable income
5	Facility Name and Address	Address of the facility that rendered the services
6	Patient/Patient Number	The name of the individual who received the service and the patient's account number assigned by the facility.
7	Claim Number	The Blue Cross number assigned to the claim
8	Group/Sub Number	The number that identifies the group and member insured by BCBSNM
9	Admit, From, End Date	The date of admission and beginning and ending dates of service
10	Days/Treatment	The number of days or treatments
11	DRG Code	The Diagnosis Related Group code used to adjudicate the claim
12	Provider Charge	The amount billed for the services
13	Other Payable/Withhold	Dollars in excess of the facility allowed amount
14	Facility Allowable	The amount allowed for the claim
15	Adjusted Provider Charge	Coincides with the facility allowable
16	Managed Care Deduction(s)	Utilized on managed care products if service guidelines / criteria was not met (i.e.; preauthorization was not obtained etc.)
17	Total Amount Paid	The amount paid for the services
18	Messages/Reasons	Any messages or reason codes related to the charges.
19	Portion Eligible for Payment by Another Carrier/Medicare	The amount of charges paid by another carrier
20	Total Deductions/Other Ineligible	The amount of other carrier payments and ineligible charges
21	Patient's Share	Amount patient pays. Providers may bill this amount to the patient.
22	Provider Claims Amount Summary	How this claim(s) were adjudicated
23	Messages	The description for messages relating to: non-covered services, program deductions, and PPO reductions

Note: Not all PCSs are the same; this PCS is provided as a sample.

8.16 Billing Dispute External Review Process

Billing Dispute Process

Effective November 21, 2008, Medical Doctors and Doctors of Osteopath (MDs/DOs) may file a post-service provider appeal to resolve disputes limited to the application of coding and payment rules and methodology related to ClaimsXten, bundling, and modifiers. Blue Cross and Blue Shield of New Mexico's internal appeal process must be exhausted before an external appeal will be considered. The provider appeals are conducted by an independent review organization, MES Solutions.

An appeal can be submitted online, by fax, or by mail. The guidelines for submitting an appeal and the applicable fees can be found at [MES Solutions](#).

For 2010, Health Care Service Corporation received 8,353 appeals for external review, with 22% overturned.

8.17 Attachments

- [Coordination of Benefits Form \(COB\)](#)
 - [Provider Refund Form](#)
 - [Claim Review Form](#)
 - [CMS-1500 User Guide](#)
 - [UB-04 User Guide](#)
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