

## **8 Claims Submission**

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. Please see Electronic Claim Filing below for more information.

### **8.1 Contacts**

- **Provider Service Unit (Claims questions – initial contact)**  
Phone **1-888-349-3706**
- **Electronic Claims Filing**
  - Availity
    - Phone **1-800-282-4548**
    - [www.availity.com](http://www.availity.com)
  - EDI
    - Phone **1-800-746-4614**
- **Eligibility and Benefits**
  - Availity
    - Phone **1-800-282-4548**
    - [www.availity.com](http://www.availity.com)
  - HealthXnet
    - Phone **1-866-676-0290**
    - [www.healthxnet.com](http://www.healthxnet.com)
  - Interactive Voice Response (IVR)
    - Phone **1-888-349-3706**

### **8.2 Required Claims Submission Information**

Submit claims within 180 days of the date of service. **Claims submitted beyond this time frame will be denied.** See information about timely claims filing under 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.

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 (version 08/05) claim form and the UB-04 (CMS-1450) 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](http://bcbsnm.com) (select *Providers*, and then [Claim Filing](#).)

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 CPT 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 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

### **Splitting Charges on Claims**

When billing for services provided, codes should be selected that best represent the services furnished. 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 (08/05) claim form when possible. When more than six services are provided, multiple CMS-1500 (08/05) claim forms may be necessary.

## **8.3 National Provider Identifier (NPI)**

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. Your NPI replaces the different provider identifiers used previously for each health plan. *You can no longer submit claims using your old provider numbers.*

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

Please visit the [National Provider Identifier](#) page in the Provider Library of our website at [bcbsnm.com](http://bcbsnm.com) for a variety of provider education resources, including NPI training materials, Communications library, Frequently Asked Questions (FAQs), and an NPI Glossary. If you have questions, you may also contact your Network Management Provider Representative.

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

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

## **8.4 Electronic Claims Submission**

BCBSNM strongly encourages the electronic submission of claims. Since editing begins prior to an electronic claim entering our processing system, electronic claims are less likely to be returned for additional information and are usually adjudicated quicker than claims submitted via paper. Electronic submission also enables users to have same day access to their batch reports, which allows for quicker error resolution and also expedites the overall revenue management cycle process.

The electronic payer ID for Blue Cross and Blue Shield of New Mexico (BCBSNM) is 00790 and is recognized nationally by clearinghouses in order to route electronic claims to BCBSNM. All electronic claims submitted to BCBSNM, including BlueSalud must be routed with payer ID 00790. The only exception is our Blue Medicare PPO product which needs to be electronically routed with payer ID NMPPPO.

Claims may be submitted electronically 24 hours a day, seven days a week. All BCBSNM facility (UB04) and professional (CMS-1500 version 08/05) claims (excluding adjustments) can be filed electronically at no charge through the Availity<sup>®</sup> Health Information Network (Availity, LLC, formerly known as THIN, Inc.).

Availity is a HIPAA 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.

In addition to an all-payer clearinghouse, Availity offers a secure Internet portal for providers to interact with the payers in the Availity network. Services offered free of charge to providers on the Availity portal include:

- Quick Claim-Online Claim Entry and Submission
- Statistical reporting tools

Availity does not distribute software for electronic medical claims submission; however, Availity does maintain a list of software vendors and claims clearinghouses that have been approved for electronic submissions.

Availity provides a toll-free electronic data interchange (EDI) helpline staffed with EDI specialists and regional Availity representatives who can help assess your EDI needs and recommend the appropriate services that may decrease administrative costs. To speak to an Availity representative, call **1-800-AVAILITY (1-800-282-4548)**.

You may also visit Availity's website at [availity.com](http://availity.com) to access a fully functional demo, view a listing of vendors and clearinghouses that partner with Availity, or directly register your organization with the Availity Health Information Network.

Note: for any electronic funds transfer (EFT) and electronic remittance advice (ERA) questions, call the Electronic Commerce Center at **1-800-746-4614**.

## **8.5 Paper Claims Submission**

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 (version 08/05) claim form and the UB-04 (CMS-1450) 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](http://bcbsnm.com) (select *Providers*, and then [Claim Filing](#).)

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

For out-of-state claims filing, see the attachment, *BlueCard Program Provider Manual* in Section 20, **Attachments**.

## **8.6 Corrected Claims Submission**

All CMS-1500 corrected claims must be submitted on paper with the [Provider Request for Claim Review Form](#) attached to the top of the claim. Please mail this form and your corrected claim to:

Blue Cross and Blue Shield of New Mexico  
ATTN: Mail Services  
P.O. Box 27630  
Albuquerque, NM 87125

Please check the “Corrected Claim” box and specify the corrections. This will ensure timely and accurate processing and will help to reduce duplicate claim denials. 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.

UB-04 corrected claims should be submitted electronically whenever possible. If you must file the UB-04 corrections on paper, please attach the [Provider Request for Claim Review Form](#) following the above instructions. In addition, when filing corrected UB-04 claims, use the appropriate Type of Bill indicating a corrected claim (e.g., 117 vs. 111).

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.

## **8.7 BlueCard Program**

All BlueCard related information is now provided in [The BlueCard Program Provider Manual](#). The full manual is included as an attachment in Section 20, **Attachments**.

## **8.8 Provider Claim Summary (PCS)**

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 Claim Summaries (EPS) are available; see Section 9, **e-Business Tools**.

### **New features of the PCS**

- Patients 65 and older are noted (indicating Medigap)
- Combined reporting: multiple patients will be listed on one PCS for ASO groups
- New 8-1/2 by 11-inch size for easier filing
- Multiple patient claims will be listed on one summary for ASO groups
- The NPI number is included, as this number *replaced* the BCBSNM provider number as of May 23, 2008.

### **The PCS still shows**

- 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 will be 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 PCS on the next page is only a **reference** for the new format. Your summary may be slightly different than the sample.

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 Provider Service Unit at **1-888-349-3706**.

**Provider Claim Summary Example** (See field explanations on next page)



DATE: MM/DD/YY **1**

PROVIDER IDENTIFIER: 0001112222 **2**

VOUCHER NUMBER: 123456789 **3**

TAX IDENTIFICATION NUMBER: 987654321 **4**

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

**PROVIDER CLAIM SUMMARY**

ANY MESSAGES WILL APPEAR ON PAGE 1

**6** PATIENT: JOHN DOE

**7** AGE: 67

**8** CLAIM NO: 0000611112222344C

**9** IDENTIFICATION NO: P06666-XOC123456789

**10** PATIENT NO: 001001

<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>
BEGIN DATE	END DATE	TS*	PS*	AMOUNT BILLED	AMOUNT PAID	OVER**** MAX ALLOW	DEDUCTIONS/OT HER INELIGIBLE	SERVICES NOT COVERED
01/01/96	01/01/96	006	01	80.00	50.00	11.00	19.00	(1) 0.00
				80.00	50.00	11.00	19.00	0.00

**20** AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$50.00

\*\*\*DEDUCTIONS/OTHER INELIGIBLE\*\*\*

<b>21</b>	CONTRACT DEDUCTIBLE:	19.00
<b>22</b>	DEDUCTIONS/OTHER INELIGIBLE:	\$19.00
<b>23</b>	PATIENT'S SHARE:	\$19.00

\*\*\*\* YOUR SUBMITTED CHARGE EXCEEDS THE MAXIMUM ALLOWANCE. AS A PARTICIPATING PHYSICIAN, YOU HAVE AGREED TO ACCEPT THIS PAYMENT IN FULL AND NOT BILL OUR MEMBER FOR THE AMOUNT EXCEEDING THE MAXIMUM ALLOWANCE.

<b>24</b>			
AMOUNT PAID TO PROVIDER:	\$80.00	AMOUNT OVER U & C:	\$0.00
AMOUNT PAID TO MEMBER:	\$50.00	AMOUNT OF SERVICES NOT COVERED:	\$19.00
NUMBER OF CLAIMS:	1	AMOUNT PREVIOUSLY PAID:	
		AMOUNT OVER MAXIMUM ALLOWANCE:	\$11.00

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

**26** \*\*PLACE OF SERVICE (PS)  
01. HOSPITAL INPATIENT.

**27** MESSAGES: (1). A CONTRACT DEDUCTIBLE HAS BEEN TAKEN.

September 2009

BCBSNM

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## Provider Claim Summary Field Explanations

<b>1</b>	<b>Date</b>	Date the summary was finalized
<b>2</b>	<b>Provider Identifier</b>	NPI
<b>3</b>	<b>Check Number</b>	The number assigned to the check for this summary
<b>4</b>	<b>Tax Identification Number</b>	The number that identifies your taxable income
<b>5</b>	<b>Provider or Group Name and Address</b>	Address of the provider/group who rendered the services
<b>6</b>	<b>Patient</b>	The name of the individual who received the service
<b>7</b>	<b>Age</b>	Patient's age
<b>8</b>	<b>Claim Number</b>	The Blue Shield number assigned to the claim
<b>9</b>	<b>Identification Number</b>	The number that identifies the group and member insured by BCBSNM
<b>10</b>	<b>Patient Number</b>	The patient's account number assigned by the provider
<b>11</b>	<b>Begin Date/End Date</b>	The beginning and ending dates of services rendered
<b>12</b>		
<b>13</b>	<b>TS</b>	Type of service
<b>14</b>	<b>PS</b>	Place of service
<b>15</b>	<b>Amount Billed</b>	The amount billed for each procedure/service
<b>16</b>	<b>Amount Paid</b>	The amount paid for each procedure/service
<b>17</b>	<b>Over Max Allow</b>	The amount exceeding the schedule of maximum allowances for the Plan. The patient is not responsible for this amount. This is the provider's write-off.
<b>18</b>	<b>Deductions/Other Ineligible</b>	Program deductions, copayments, and coinsurance amounts
<b>19</b>	<b>Services Not Covered</b>	Non-covered services according to the member's contract
<b>20</b>	<b>Amount Paid to Provider for This Claim</b>	The amount Blue Shield paid to provider for this claim
<b>21</b>	<b>Contract Deductible</b>	The deductible amount applied to this claim (patient's responsibility)
<b>22</b>	<b>Deductions/Other Ineligible</b>	Same as field 18
<b>23</b>	<b>Patient's Share</b>	Amount patient pays. Providers may bill this amount to the patient.
<b>24</b>	<b>Claim Summary Section Totals</b>	How this claim was adjudicated
<b>25</b>	<b>Type of Service (TS)</b>	The description for the type of service code used in field 13
<b>26</b>	<b>Place of Service (PS)</b>	The description for the place of service code used in field 14
<b>27</b>	<b>Messages</b>	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.

## **8.9 Recoupment Process**

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 \$1 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**

## **8.10 Timely Filing**

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

### **Timely Filing Appeals Process**

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

#### **Proof of timely filing**

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:

<b>Proof</b>	<b>Examples</b>
<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"> <li>• Account ledger posting that includes multiple patient submissions</li> <li>• Patient ledger</li> <li>• BCBSNM returned claim sheet</li> <li>• UB-04 with date of original submission in box 86</li> </ul>
<p><u>Electronic Filer:</u></p> <p>Copy of BCBSNM or provider's clearinghouse confirmation report <b>with patient detail</b></p> <p><b>Note:</b> The provider is responsible for submitting a corrected claim through EDI within the 180-day limit</p>	<ul style="list-style-type: none"> <li>• EMC Input Transaction Report</li> <li>• Blue Cross Data Collection – BCBSNM</li> <li>• Accepted Claims Report</li> </ul> <p><b>Note:</b> A BCBSNM rejection report or a report from the provider's clearinghouse <b>without patient detail</b> 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"> <li>• Medicare EOB</li> <li>• Other insurance EOB or EOP</li> </ul>
<p>Proof of follow-up with member for lack of insurance information</p> <p><b>Note:</b> Member <b>is</b> responsible for providing current and appropriate insurance information to the provider</p>	<ul style="list-style-type: none"> <li>• Copies of dated letters requesting information from member</li> </ul>
<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"> <li>• Copy of EOB from other insurance carrier showing denial</li> </ul>
<p>Enrollment issues are reviewed on a case-by-case basis</p>	<ul style="list-style-type: none"> <li>• Member not enrolled, claim returned to provider</li> </ul>
<p>Third-party liability issues are reviewed on a case-by-case basis</p>	<ul style="list-style-type: none"> <li>• Additional information will be requested from the member and/or provider of services</li> </ul>
<p>Legal incapacity issues are reviewed on a case-by-case basis</p>	<ul style="list-style-type: none"> <li>• Physical illness</li> <li>• Mental condition</li> <li>• Death of contract holder</li> <li>• Death of provider</li> </ul>

## **8.11 Eligibility and Benefits**

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).

### **8.11.1 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.

Note: Please refer to Section 9, **e-Business** for more about the [IVR Caller Guide](#), including useful self-service tools.

### **8.11.2 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.

In addition to an all-payer clearinghouse, Availity offers a secure Internet portal for providers to interact with the payers in the Availity network. Services offered free of charge to providers on the Availity portal include:

- Quick Claim-Online Claim Entry and Submission
- Statistical reporting tools
- Eligibility and Benefits
- Claim Status Inquiry

Availity provides a toll-free electronic data interchange (EDI) helpline staffed with EDI specialists and regional Availity representatives who can help assess your EDI needs and recommend the appropriate services that may decrease administrative costs. To speak to an Availity representative, call **1-800-AVAILITY (1-800-282-4548)**.

### **8.11.3 HealthXnet**

HealthXnet allows you to check member eligibility, benefit 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](http://www.healthxnet.com)

## **8.12 Processing 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 of injury-related claims, please submit, along with your claim form, information regarding how, when, and where the injury occurred.

<b>ICD-9 Code</b>	<b>Diagnosis</b>
005 - 0059	Other food poisoning (bacterial)
353 - 3559	Nerve root and plexus disorders
451 - 4519	Phlebitis and thrombophlebitis
500 - 505	Coal workers' pneumoconiosis
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 - 5519	Other hernia of abdominal cavity, with gangrene
552 - 5529	Other hernia of abdominal cavity, with obstruction, but without mention of gangrene
553 - 55329	Other hernia of abdominal cavity without mention of obstruction or gangrene
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
800 - 9579	Injury, trauma, and poisoning
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
344 - 3449	Other paralytic syndromes
9583 - 9599	Post-traumatic wound infection, not elsewhere classified
9588 - 9599	Other early complications of trauma
992 - 9950	Effects of heat and light
996 - 99679	Complications peculiar to certain specified procedures
9969 - 99699	Complications of reattached extremity or body part
7289 - 729	Unspecified disorder of muscle, ligament, and fascia
5538 - 5539	Hernia of other specified sites

## **8.13 Coordination of Benefits (COB)**

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.

## **8.14 ClaimCheck® Software Program**

BCBSNM utilizes version 41 of McKesson's ClaimCheck software editing program, implemented October 13, 2008, to assist in the process of provider claim reimbursement decisions. The ClaimCheck system is one of the programs used in the environment of the increasingly complex developments in medical technology and procedural coding (CPT, HCPCS) used to process provider reimbursement determinations.

The software 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. ClaimCheck edits are supported by clinical studies published in professional journals or approved by national professional organizations.

Using ClaimCheck 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.

ClaimCheck edits do not mirror those of the national Corrective Coding Initiative (CCI), 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 ClaimCheck bundling edits for specific procedure code combinations. See more about C3 in Section 8.14.

ClaimCheck specifically addresses three CPT billing practices:

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

Code	Narrative	Charge
58150	Total abdominal hysterectomy (TAH), with or without removal of tubes and ovaries	\$1,900
51840	Attach bladder/urethra (urethropexy)	\$600
58720	Removal of ovary/tube(s) (salpingo-oophorectomy)	\$520

**Rebundles** to 58152 TAH, with or without removal of tubes and ovaries. Charges will be aggregated and the appropriate allowance applied to added code 58152.

**2. 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.

**3. 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
33430	Replacement, mitral valve, with cardiopulmonary bypass	\$3,600
33425	Valvuloplasty, mitral valve, with cardiopulmonary bypass	\$3,200

Procedure code 33425 is **mutually exclusive** to 33430. The charges will be aggregated and the appropriate allowance applied to 33430.

**Procedure for Provider Reconsideration Requests of ClaimCheck bundled or rejected charges** – If you have a question or dispute concerning a bundled or rejected charge that is related to a ClaimCheck edit determination, contact the Provider Service Unit (PSU) at BCBSNM within one year from the date of service: **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 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.

## **8.15 Clear Claim Connection™**

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](http://www.availity.com) to sign up if you are not currently an Availity user.

### **8.15.1 Modifiers**

Modifiers are important for correct results during Claim Check 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. Clear Claim Connection (C3) can be used to determine the result of ClaimCheck bundling edits for specific procedure code combinations.

**Note:** 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 modifiers for the 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 Current Procedural Terminology (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 Claim Check editing logic for the procedure codes, and the modifier indicators on the National Correct Coding Initiative (NCCI) data for the procedures codes. Providers can utilize the Claim Check online tool and Clear Claim Connection (C3) to determine the results of a particular scenario. The tool allows entry of up to four (4) modifiers.

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

## **8.16 Billing Dispute External Review 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 ClaimCheck, 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](#).

## **8.17 Attachments**

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