BlueCross BlueShield of Texas

Recoupment Process for Blue Essentials℠, Blue Premier℠ and Blue Advantage HMO℠

The "Refund Policy for **Blue Essentials, Blue Premier and Blue Advantage HMO**" states that **Blue Essentials, Blue Premier, and Blue Advantage HMO** has 180 days following the payee's receipt of an overpayment to notify a Physician or Provider that the overpayment has been identified and to request a refund.* For additional information on the **Blue Essentials, Blue Premier and Blue Advantage HMO** Refund Policy, including when a Physician or Provider may submit a claim review and when an overpayment may be placed into recoupment status, please refer to the "**Refund Policy**" in Section F in the **Blue Essentials, Blue Premier and Blue Advantage HMO Physician, Professional Providers, Facility and Ancillary Provider Manual** or go back to the Recoupments/Refunds section on the BCBSTX provider website.

In some unique circumstances a Physician or Provider may request, in writing, that **Blue Essentials, Blue Premier or Blue Advantage HMO** 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 **Blue Essentials, Blue Premier or Blue Advantage HMO** accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:

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

Recoupment Process
Blue Essentials, Blue Premier and Blue Advantage HMO

When a Physician's or Provider's overpayment is placed into a recoupment status, the claims system will automatically off-set future claims payment and generate a Provider Claims Summary (PCS) to the Physician or Provider (Recoupment Process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable **Blue Essentials, Blue Premier or Blue Advantage HMO** claim(s).

To view an example of a recoupment, please refer to the sample PCS on page 2 below or go to Section F in the **Blue Essentials (formerly known as HMO Blue Texas), Blue Premier and Blue Advantage HMO Physician, Professional Providers, Facility and Ancillary Provider Manual.**

For additional information or if you have questions regarding the Blue Essentials or Blue Advantage HMO Recoupment Process, please contact **800- 451-0287** to speak with an **Blue Essentials, Blue Premier or Blue Advantage HMO** Customer Advocate.

Sample PCS Recoupment

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

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

ANY MESSAGES WILL APPEAR ON PAGE 1

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

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

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

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: $50.52

DEDUCTIONS/OTHER INELIGIBLE

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

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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	RECOUPMENT AMOUNT:	$31.52
AMOUNT OF SERVICES NOT COVERED:	$25.48	NET AMOUNT PAID TO PROVIDER:	$19.00
AMOUNT PREVIOUSLY PAID:	$0.00		

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

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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.

Continued on next page

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	**PAY**	Reimbursement payment rate that was applied in relationship to the member's policy type
14	**Procedure Code**	The code that identifies the procedure performed
15	**Amount Billed**	The amount billed for each procedure/service
16	**Allowable Amount**	The highest amount 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	**Messages**	The description for messages relating to: non-covered services, program deductions, and PPO reductions