



# BlueCross BlueShield of Texas

## Refund Policy – HMO Blue Texas

HMO Blue Texas strives to pay claims accurately the first time; however, when payment errors occur, HMO Blue Texas needs your cooperation in correcting the error and recovering any overpayment.

### **When a Physician, Hospital or Other Health Care Provider Identifies an Overpayment:**

- If you identify a refund due to HMO Blue Texas, please submit your voluntary refund to the following address:

Blue Cross and Blue Shield of Texas  
Attn: Cash Receipts Department  
P.O. Box 805107  
Chicago, IL 60680-4112

- Download [Voluntary Refund Form](#)

### **When HMO Blue Texas Identifies an Overpayment:**

If HMO Blue Texas identifies an overpayment, a refund request letter will be sent to the payee within 180 days following the payee's receipt of the overpayment that explains the reason for the refund and includes a remittance form and a postage-paid return envelope.\* In the event that HMO Blue Texas 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 Appeal Deadline), the physician, hospital or other health care provider may request an appeal/reconsideration of the overpayment determination by HMO Blue Texas by submitting a Physician and Provider Request for Claim Appeal/Reconsideration Review (Claim Appeal) form in accordance with the Claim Appeal/Reconsideration Review Process referred to below. In determining whether this deadline has been met, HMO Blue Texas will presume that the refund request letter was received on the 5<sup>th</sup> business day following the date of the letter.
- If HMO Blue Texas does not receive payment in full within the Overpayment Appeal Deadline, we will recover the overpayment by offsetting current claims reimbursement by the amount due HMO Blue Texas (Recoupment Process) after the later of the expiration of the Overpayment Appeal Deadline or the completion of the Claim Appeal/Reconsideration Review Process provided that the physician or provider has submitted the Claim Appeal form within the Overpayment Appeal Deadline.
- For information concerning the Recoupment Process, see "Recoupment Process – HMO Blue Texas" in the same Refunds/Recoupment section on the BCBSTX Web site as this article.

**Note:** In some unique circumstances a physician, hospital or other 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 HMO Blue Texas Refund Policy, please contact **1-866-825-6012** to speak with a HMO Blue Texas Customer Service Representative. If you want to appeal the overpayment decision, click on the following link – [Claim Appeal/Reconsideration Review Process](#). You can also locate the Claim Appeal/Reconsideration Review Process on the BCBSTX Web site, at the web address shown above. The information is under the Claim Appeal/Reconsideration Review Process in the Provider Library section.

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\* 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
- Employee Retirement System
- Texas Health Insurance Risk Pool
- 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

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## Refund Letters – Identifying Reason for Refund

HMO Blue Texas' refund request letters include information about the specific reason for the refund request, *for example*:

- Your claim should have been authorized and processed by American Imaging Management (AIM).
- The services rendered require *Preauthorization/Referral*; none was obtained.
- Your claim was processed with an *incorrect copay/coinsurance or deductible*.
- Your claim was received after the timely filing period; *proof of timely filing needed*.
- Your claim was processed with the *incorrect fee schedule/allowed amount*.
- Your claim should be submitted to the *member's IPA or Medical Group*.
- Your claim was processed with the *incorrect anesthesia time/minutes*.
- Your claim was processed with in-network benefits; however, it should have been processed with *out-of-network benefits*.
- Total charges processed exceeded the amount billed.
- Per the Member/Provider this claim was submitted in error.
- *Medicare should be primary* due to ESRD. Please file with Medicare and forward the EOMB to BlueCross/BlueShield.
- The patient has *exceeded the age limit* and is not eligible for services rendered.
- The patient listed on this claim is *not covered under the referenced policy*.
- The dependent was *not a full time student* when services were rendered; benefits are not available.
- The claim was processed with *incorrect membership information*.
- The services were performed by the anesthesiologist; however, they were *paid at the surgeon's benefit level*.
- The services were performed by the assistant surgeon; however, they were *paid at the surgeon's benefit level*.
- The services were performed by the co-surgeon; however, they were *paid at the surgeon's benefit level*.
- The service rendered was considered a *bilateral procedure*; separate procedure not allowed.
- Claims submitted for rental; *DME has exceeded purchase price*.
- Duplicate payments were made on these charges.
- Benefits were incorrectly coordinated with Medicare.
- Benefits were incorrectly coordinated with another insurance carrier.
- Medical Review determined the charges to be Pre-existing.
- Medical Review determined the charges to be cosmetic.
- Medical Review determined the charges to be Not Medically Necessary.
- Medical Review determined the charges to be Not Covered.
- Benefits were paid, however, the patient's insurance coverage was not in effect on the date(s) of service.
- Claim payment was intended for another provider.
- A corrected claim submission resulted in an overpayment.