INTRODUCTION AND GENERAL CLAIMS GUIDELINES

We need your help to achieve BCBSTX’s goal of accurate and efficient claims payment. Share the following guidelines with your staff and, if applicable, with your billing service agent and electronic data processing service agent. It is important that everyone involved understands the guidelines for preparing and submitting claims for services rendered to BCBSTX members.

*For LTSS billing, see Chapter 8.
THE IMPORTANCE OF A CLEAN CLAIM

This section will help you understand how to submit a claim to BCBSTX correctly the first time, which will help avoid delays in processing.

Claims submitted correctly the first time are called ‘clean’. That means that all required fields have been completed in accordance with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements. It also means that the correct form was used for the type of service provided.

We return claims submitted with incomplete or invalid information, and request the claim be corrected and resubmitted. If using a clearinghouse for Electronic Data Interchange (EDI), the clearinghouse/gateway also rejects claims that are incomplete or invalid. You are responsible for working with your EDI vendor to help ensure that claims that ‘error out’ from the EDI gateway are corrected and resubmitted.

McKesson ClaimsXten™

For Blue Cross and Blue Shield of Texas Medicaid-State of Texas Access Reform (STAR Kids) BCBSTX uses claims editing software from McKesson called ClaimsXten. ClaimsXten incorporates the McKesson editing rules that determine whether a claim should be paid, rejected or requires manual processing.

These editing rules assess Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes on the CMS-1500 form. A claim auditing action then determines how the procedure codes and code combinations will be adjudicated. The auditing action recognizes historical claims related to current submissions and may result in adjustments to previously processed claims. You can find descriptions of specific reimbursement policies in this manual.

ClaimsXten may be updated periodically. BCBSTX will give providers advance notice per your provider agreement. For the latest information and current ClaimsXten rules, you can log into our website at http://bcbstx.com/provider/medicaid/index.html and scroll down to Claims.

Claim Forms

Generally, there are two types of forms used for submitting claims for reimbursement. They are:

1. The CMS-1500 for professional services (refer to the CMS-1500 Claim Form section)
2. The CMS-1450 (UB-04) for institutional services (refer to the CMS-1450 (UB-04) Claim Form section)

These forms are available in both electronic and hard copy/paper format.

Information on how to complete each of these forms is available later in this Manual. Click on the appropriate form name in the Claim Forms and Filing Limits table to link to a sample image of that form followed by general instructions on how to complete its more important fields.
Claim Filing Limits

All claims must be submitted within the contracted filing limit to be considered for payment. We will deny claims that are received past the filing limit. See the Submitting a Claim section for standard claim filing and processing time frames.

Submit claims as soon as possible following delivery of service to avoid delays in processing.

BCBSTX is not responsible for a claim never received. Prolonged periods before resubmission may cause you to miss the filing limit. Determine filing limits as follows:

- If BCBSTX is the primary payer, you have a specific length of time between the last date of service on the claim and the BCBSTX receipt date.
- If BCBSTX is secondary payer, you have a specific length of time between the other payer’s Remittance Advice (RA) date and the BCBSTX receipt date.

### CLAIM FORMS AND FILING LIMITS

<table>
<thead>
<tr>
<th>Form</th>
<th>Type of Service to be Billed</th>
<th>Time Limit to File (Refer to the Provider contract to confirm correct filing limits for claims.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1500 Claim Form</td>
<td>Physician and other professional services:</td>
<td>Within 95 days of date of service</td>
</tr>
<tr>
<td></td>
<td>Ancillary services including:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical, occupational and speech therapy, audiologists, ambulance, ambulatory surgical center, dialysis, durable medical equipment (DME), diagnostic imaging centers, hearing aid dispensers, home infusion, hospice, laboratories, prosthetics and orthotics, and free standing SNFs.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some ancillary providers may use a CMS-1450 (UB-04) if they are ancillary institutional providers. Ancillary charges by a hospital are considered facility charges.</td>
<td></td>
</tr>
<tr>
<td>CMS-1450 (UB-04) Claim Form</td>
<td>Hospitals, institutions, home health services and ancillary providers</td>
<td>Within 95 days of date of service (If the member is an inpatient for longer than 30 days, interim billing is required as described in the hospital agreement.)</td>
</tr>
</tbody>
</table>
## OTHER FILING LIMITS

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
<th>Time Frame</th>
</tr>
</thead>
</table>
| **Third Party Liability (TPL) or Coordination of Benefits (COB)**       | If the claim has TPL or COB or requires submission to a third party before submitting to BCBSTX, the filing limit starts from the date of the notice from the third party. | From date of notice from third party:  
  - 95 Days for CMS-1500 claims  
  - 95 Days for CMS-1450 (UB-04) claims |
| **Checking Claim Status**                                               | Should you have a question about claims processing, as the first point of contact, contact your electronic connectivity vendor, i.e. Availity, your preferred vendor or by calling Customer Service. | 30 business days after BCBSTX’s receipt of claim, contact Customer Service at:  
  **1-877-688-1811**; TTY: **7-1-1** |
| **Provider Dispute**                                                    | To request a claim appeal, send your request in writing to:  
  **Blue Cross and Blue Shield of Texas**  
  **Attn: Complaints and Appeals**  
  PO Box 27838  
  Albuquerque, NM 87125-7838  
  You may also use our **Provider Appeal Request Form**. | 120 calendar days from the receipt of BCBSTX Remittance Advice (RA) or notice of action.                                                                                                                     |
PROVIDERS NOT CONTRACTED WITH BCBSTX

BCBSTX accepts the following claims from non-contracted providers within the indicated time frames:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>In-State or Within 50 Miles of State Border</th>
<th>Out-of-State</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Services</td>
<td>95 days from the date of service or discharge date</td>
<td>365 days</td>
</tr>
<tr>
<td>Texas Medicaid Enrolled</td>
<td>95 days with prior authorization if services are not available in Texas</td>
<td>365 days with prior authorization if services are not available in Texas</td>
</tr>
<tr>
<td>Newly Enrolled in Texas Medicaid</td>
<td>Within 95 days of the date the new provider identifier is issued, and within 365 days of the date of service</td>
<td>365 days with prior authorization if services are not available in Texas</td>
</tr>
<tr>
<td>Non-Texas Medicaid Enrolled</td>
<td>Denied unless prior authorized for services not available in Texas</td>
<td>Denied unless prior authorized for services not available in Texas</td>
</tr>
</tbody>
</table>

PAPER CLAIMS AND CORRESPONDENCE MAILING ADDRESS

Blue Cross and Blue Shield of Texas  
Attn: Claims  
PO Box 51422  
Amarillo, TX 79159-1422

If feasible, providers will be notified in writing of any changes in the claims submission address at least 30 days prior to the effective date of coverage. If we are unable to provide 30-day notice, a 30-day extension will be added to the claim’s filing deadline to help ensure claims are routed to the correct processing center.

Questions about Claims

If you have questions about claims status or how to file a claim, including how to complete claims forms, please contact the Customer Service at 1-877-688-1811.
SUBMITTING A CLAIM

Methods for Submitting Claims

There are three methods for submitting a claim:
1. Electronic Data Interchange (EDI) (preferred)
2. Paper or hard copy
3. Provider Portal Information

Electronic Claims

Submit claims electronically through a plan-approved electronic billing system software vendor and/or clearinghouse.

If you use EDI, you must include the following provider information:
- Provider name
- Rendering Provider NPI (National Provider Identifier)
- Group NPI (National Provider Identifier)
- Referring or ordering provider NPI
- The Federal Provider Tax Identification (ID) number
- BCBSTX’s Payer Identification (ID) number 66001 (Verify this number with your clearinghouse, as it may be different for this payer within their processes.)

BCBSTX cannot be responsible for claims never received. You must work with your vendors to help ensure files are successfully submitted to BCBSTX. Failure of a third party to submit a claim to BCBSTX may risk your claim being denied for untimely filing if those claims are not successfully submitted during the filing limit.

After submitting electronic claims, do the following:
- Monitor claim status on the provider portal or through the BCBSTX Customer Service Interactive Voice Response (IVR) at 1-877-688-1811. Please note that the IVR accepts either your billing National Provider Identifier (NPI) or your Federal Tax Identification Number (TIN) for provider identification. Should the system not accept your billing NPI or Federal TIN, the system will route your call to a Customer Service representative who will help you with your query. For purposes of assisting you, we may ask you for your TIN.
- Watch for (and confirm) plan Batch Status Reports from your vendor/clearinghouse to help ensure your claims have been accepted by BCBSTX.
- Correct any errors and resubmit the claim (electronically) immediately to prevent denials due to untimely filing.

A front-end edit process may occur with your contracted vendor and/or clearinghouse. If claims do not meet the required HIPAA compliance standards, the claim may be ‘rejected’ by your EDI vendor or clearinghouse. An error report will be sent to you and your claim will never reach BCBSTX’s EDI gateway. You will need to review these reports and file again.

For EDI claims submissions that require attachments, please contact your clearinghouse for guidelines.

Contact BCBSTX’s Electronic Data Interchange (EDI) unit at 1-800-746-4614 to:
- Learn more about EDI and how to get connected.
- Get technical assistance and support. For existing accounts, call 1-800-746-4614.
Paper Claims

Paper claims are scanned for clean and clear recording of data. To get the best results, paper claims must be legible and submitted in the proper format. Follow these paper claim submission requirements to speed processing and prevent delays:

- Use the correct form and be sure the form meets Centers for Medicare and Medicaid Services (CMS) standards
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it
- Do not stamp or write over boxes on the claim form
- Send the original claim form to BCBSTX, and retain the copy for your records
- Do not staple original claims together; BCBSTX will consider the second claim as an attachment and not an original claim to be processed separately
- Type information within the designated field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a dot matrix printer, do not use ‘draft mode’ since the characters generally do not have enough distinction and clarity for the optical character reader to accurately read the contents.

When submitting paper claims, the following provider information must be included:

- Provider Name
- Rendering Provider Group or Billing Provider
- The Federal Provider Tax Identification (ID) number
- National Provider Identifier (NPI)
- Medicare number (if applicable)
- Ordering or referring provider NPI

Attachments to Paper Claims

Some claims may require additional attachments. Be sure to include all supporting documentation when submitting your claim.

Paper Claim Submission Mailing Addresses

Mail paper claims for BCBSTX to:

Blue Cross and Blue Shield of Texas
Attn: Claims
PO Box 51422
Amarillo, TX 79159-1422
PROVIDER PORTAL
Availity™ Patients, Not Paperwork Overview Availity optimizes the flow of information between health care professionals, health plans and other health care stockholders through a secure internet-based exchange. The Availity Health Information Network encompasses administrative and clinical services, supports both real-time and batch transactions via the Web and electronic data interchange (EDI) and is HIPAA compliant. For more information, visit www.availity.com, call 1-800-AVAILITY (282-4548) or email PECS@hcsc.net.

Submit claims electronically through the Availity™ web portal, a plan-approved electronic billing system software vendor and/or clearinghouse. Through the provider portal, you can also check eligibility, benefits, claim status, submit appeals and medical record attachments.

BEHAVIORAL HEALTH CLAIMS
Claims for behavioral health services can be submitted to:

Magellan
Attn: Claims
P.O. Box 2154
Maryland Heights, MO 63043

CLINICAL SUBMISSIONS CATEGORIES
Following is a list of claims categories that may require routine submission of clinical information before or after payment of a claim:
- Claims involving precertification/prior authorization/predetermination (or some other form of utilization review) including but not limited to:
  - Claims pending for lack of precertification or prior authorization
  - Claims involving medical necessity or experimental/investigative determinations
  - Claims involving drugs administered in a physician’s office requiring prior authorization
  - Claims requiring certain modifiers
  - Claims involving unlisted codes
  - Claims for which we cannot determine from the face of the claim whether it involves a covered service; thus, the benefit determination cannot be made without reviewing medical records (including but not limited to emergency service-prudent layperson reviews and specific benefit exclusions). A prudent layperson is someone who possesses an average knowledge of health and medicine.
  - Claims that we have reason to believe involve inappropriate (including fraudulent) billing
  - Claims that are the subject of an audit (internal or external), including high-dollar claims
  - Claims for individuals involved in case management or disease management
  - Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated)
Other situations in which clinical information might routinely be requested:

- Accreditation activities
- Quality improvement/assurance activities
- Credentialing
- Coordination of benefits
- Recovery/subrogation

Examples provided in each category are for illustrative purposes only and are not meant to represent a complete list within the category.

NATIONAL PROVIDER IDENTIFIER

The National Provider Identifier (NPI) is a 10-digit number. NPIs are issued only to providers of medical and health services and supplies. NPI is one provision of the Administrative Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). NPI is intended to improve the efficiency of the health care system and reduce fraud and abuse.

There are several advantages to using your NPI for claims and billing. NPI offers providers the opportunity to bill with only one number. Some of the advantages for plan providers using NPI include the following:

- The billing process is simplified, as it is no longer necessary to maintain and use legacy identifiers for each of the plans.
- Administering changes for addresses and locations is easy.
- Providers will only have one number for electronically transacting business with any health plan with which they are affiliated.

Providers may apply for an NPI individually online at the National Plan and Provider Enumeration System (NPPES) website at [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov) or by obtaining a paper application by calling the NPPES number at [1-800-465-3203](tel:1-800-465-3203).

Unattested NPIs

BCBSTX will deny claims with an unattested NPI, even if you provide legacy information. Attestation is the process of registering and reporting your NPI with your state Medicaid agency. Providers serving Texas STAR Kids patients are required to register and attest their NPI with the State of Texas Medicaid & Healthcare Partnership (TMHP). You can attest (register and report) your NPI with Texas Medicaid and Healthcare Partnership (TMHP) at [www.tmhp.com](http://www.tmhp.com). Attesting makes processing and paying your claims more efficient and accurate. During attestation, you may also be assigned a benefit code to identify specific state programs as part of NPI-related data.

The Centers for Medicare and Medicaid Services (CMS) has developed regulations for a batch enumeration called Electronic File Interchange, or EFI. The EFI process will be available to large provider groups such as hospitals and provider practice groups.

Although a provider may not be currently billing to Medicaid or other publicly funded programs, a participating provider must still apply for an NPI with CMS. According to the NPI Final Rule, BCBSTX requires the NPI on paper claims for our participating providers.
**Online Resources for NPI Information**

The following websites offer additional NPI information:

Workgroup for Electronic Data Interchange: [www.wedi.org](http://www.wedi.org)

**BENEFIT CODES**

Submit claims with the appropriate benefit code for services, as required. For electronic claims, add the benefit code in SBR Loop 2000B, SBR03. For paper claims, add the benefit code in Box 11 on the CMS-1500 Claim Form. If you submit a claim without the benefit code when it is required, the claim will be returned for resubmission.

If a benefit code is not applicable, leave the field blank. [Include only required codes (with *)]

<table>
<thead>
<tr>
<th>Benefit Code</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCP*</td>
<td>Comprehensive Care Program (CCP) – Box 11</td>
</tr>
<tr>
<td>CSN</td>
<td>Children with Special Health Care Needs (CSHCN) Services Program Provider</td>
</tr>
<tr>
<td>DE1</td>
<td>Texas Health Steps Dental</td>
</tr>
<tr>
<td>DM2</td>
<td>Texas Medicaid Home Health DME</td>
</tr>
<tr>
<td>DM3</td>
<td>CSHCN Services Program Home Health DME</td>
</tr>
<tr>
<td>EC1</td>
<td>Early Childhood Intervention (ECI) Providers</td>
</tr>
<tr>
<td>EP1*</td>
<td>Texas Health Steps – Box 11</td>
</tr>
<tr>
<td>HA1</td>
<td>Hearing Aid</td>
</tr>
<tr>
<td>IM1</td>
<td>Immunization</td>
</tr>
<tr>
<td>MA1</td>
<td>Maternity</td>
</tr>
<tr>
<td>MH2</td>
<td>Behavioral/Mental Health Case Management</td>
</tr>
<tr>
<td>TB1</td>
<td>Tuberculosis (TB) Clinic</td>
</tr>
<tr>
<td>WC1</td>
<td>Women, Infants, and Children (WIC) Program</td>
</tr>
</tbody>
</table>

*Required codes for submission to BCBSTX for submitting claims; all other codes are required by HHSC when claims are sent to the state for reimbursement.*
FAMILY PLANNING CLAIMS SUBMISSION

BCBSTX reimburses the following family planning procedure codes:

<table>
<thead>
<tr>
<th>99201</th>
<th>99202</th>
<th>99203</th>
<th>99204</th>
<th>99205</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>99212</td>
<td>99213</td>
<td>99214</td>
<td>99215</td>
</tr>
</tbody>
</table>

BCBSTX reimburses the following family planning diagnosis codes:

<table>
<thead>
<tr>
<th>Z33011</th>
<th>Z30013</th>
<th>Z30014</th>
<th>Z30018</th>
<th>Z3002</th>
<th>Z3009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z302</td>
<td>Z3040</td>
<td>Z3041</td>
<td>Z3042</td>
<td>Z30430</td>
<td>Z30431</td>
</tr>
<tr>
<td>Z30432</td>
<td>Z30433</td>
<td>Z3049</td>
<td>Z308</td>
<td>Z309</td>
<td>Z9851</td>
</tr>
</tbody>
</table>

Family Planning follow-up visits may be billed with or without modifier FP.

BILLING REQUIREMENTS FOR CLINICIAN ADMINISTERED DRUGS

A national drug code (NDC) and Healthcare Common Procedure Coding System (HCPCS) procedure code must be submitted on all medical claims for clinician-administered drugs. If a submitted claim is missing the NDC information or the NDC is not valid for the corresponding HCPCS code, BCBSTX will deny or reject the entire claim for failing to comply with the Clean Claim Standards. This requirement applies to the STAR Kids program only.

**Entity Type 1 and Entity Type 2 Providers**

An individual health care provider should apply for an Entity Type 1 NPI. This includes, but is not limited to, physicians, dentists and chiropractors.

Organizations such as hospitals should apply for an Entity Type 2 NPI. The definition of an organization includes, but is not limited to, medical groups, group practices, Federally Qualified Health Centers and Rural Health Centers.

**Note:** Submit Texas Health Steps medical groups with Type 1 and 2 — Organization NPI as the billing NPI; do not include rendering NPI information on Texas Health Steps groups claims. BCBSTX requires benefit code **EP1** (Texas Health Steps) when filing a Texas Health Steps claim. Leave 24J blank.

Only use billing NPI Box 33A on Texas Health Steps claims for both Type 1 and Type 2 entities.

On paper claims, include this benefit code on the CMS-1500 Claim Form in box 11. Texas Health Steps claims submitted without the benefit code will be returned.

For solo or Type 1 providers, use Individual NPI in box 33A when submitting Texas Health Steps claims and include the EP1 benefit code to avoid claims returned for resubmission. Leave 24J blank.
BILLING REQUIREMENTS FOR 340B DRUG DISCOUNT PROGRAM

The 340 Drug Discount Program requires drug manufacturers to provide covered out-patient drugs to certain eligible health care entities at or below statutorily defined discount prices.

Pharmacies billing claims using pharmaceutical stock purchased under Section 340B pricing should identify these claims using National Council for Prescription Drug Program (NCPDP) values as applicable. Currently, NCPDP standard allows pharmacies to identify these claims as 340B by:
- Submitting Submission Clarification Code value 20 in field 420-DK.

COORDINATION OF BENEFITS

When applicable, BCBSTX coordinates benefits with any other carrier or program that the member may have for coverage, including Medicare. Indicate ‘Other Coverage’ information on the appropriate claim form.

If there is a need to coordinate benefits, include at least one of the following items from the other carrier or program when submitting a Coordination of Benefits (COB) claim:
- Third-party Remittance Advice (RA)
- Third-party letter explaining the denial of coverage or reimbursement

COB claims received without at least one of these items will be mailed back to you with a request to submit to the other carrier or program first. Please make sure that the information you submit explains any coding listed on the other carrier’s RA or letter. We cannot process your claim without this specific information.

BCBSTX must receive COB claims within 95 days from the date on the other carrier’s or program’s RA or letter of denial of coverage.

When submitting COB claims, specify the other coverage in:
- Boxes 9a-d of the CMS-1500 claim form
- Boxes 58-62 of the CMS-1450 (UB-04) claim form

Third-Party Recovery

You may not interfere with or place any liens upon the state’s right or BCBSTX’s right, acting as the state’s agent, to recovery from third-party billing.
CLAIMS PROCESSING

A brief description of claims processing methods follows. All paper submitted claims are assigned a unique Document Control Number (DCN). The DCN identifies and tracks claims as they move through the claims processing system. This number contains the Julian date, which indicates the date the claim was received. It monitors timely submission of a claim.

Document Control Numbers are composed of 11 digits:

- Two-digit plan year
- Three-digit Julian date
- Two-digit BCBSTX reel identification
- Four-digit sequential number

Claims entering the system are processed on a line-by-line basis except for inpatient claims. Inpatient claims are processed on a whole-claim basis. Each claim is subjected to a comprehensive series of check points called edits. These edits verify and validate all claim information to determine if the claim should be paid, denied or pended for manual review.

You are responsible for all claims submitted with your provider number, regardless of who completed the claim. If you use a billing service, you must help ensure that your claims are submitted properly.

Note: Entities submitting claims for services rendered by a health care provider are subject to Texas HHSC suspension if they submit claims for a Provider who is suspended from HHSC.

Claim Returned for Correction/Additional Information

If the claim is not clean, it will be denied and a remit will be sent explaining the denial.

Claim Filing with Wrong Plan

If you file a claim with the wrong insurance carrier and provide documentation verifying the initial timely claims filing within 95 days of the date of the other carrier’s denial letter or RA form, BCBSTX processes your claim without denying it for failure to file within filing time limits.

CLAIMS PAYMENT

Upon receiving claims, BCBSTX analyzes them for medically necessary and covered services. BCBSTX generates a Remittance Advice (RA), either paper or electronic, summarizing services rendered and payer action taken, and sends the appropriate payment amount to the provider.

BCBSTX shall adjudicate (finalize as paid or denied) a clean claim within 30 days from the date the claim is received. BCBSTX will pay providers interest at a rate of 18 percent per annum, calculated daily on clean claims that are not adjudicated within 30 days.
BCBSTX shall adjudicate (finalize as paid or denied) a clean electronic pharmacy claim within 18 days point of sale process, and paper pharmacy claim submitted no later than 21 days. BCBSTX will pay pharmacy providers interest at a rate of 18 percent per annum, calculated daily on clean claims for pharmacy claims that are not adjudicated within 18 days.

Unless otherwise noted below, physicians and other professional providers will receive payment and Remittance Advices (RAs) in a paper format.

**Electronic Fund Transfer**

BCBSTX allows the electronic fund transfer (EFT) option for claims payment transactions. This allows claims payments to be deposited directly into a previously selected bank account. You can enroll by calling EDI Services at 1-800-746-4614.

**Electronic Remittance Advices**

Providers contracted with BCBSTX can choose to receive Electronic Remittance Advices (ERAs). ERAs are received through a mailbox set up between a provider or clearinghouse and BCBSTX. Use the mailbox to send and receive ERA files, which are in an ASC X 12N 835 file format. There is no charge for the service, but enrollment is required. Providers can enroll by calling EDI Services at 1-800-746-4614.

Electronic data transfers and claims are HIPAA-compliant and meet federal requirements for EDI transactions, code sets, member confidentiality, and privacy. To enroll for Electronic Remittance Advices, go to [www.bcbstx.com/provider/claims/era.html](http://www.bcbstx.com/provider/claims/era.html).

**CLAIMS OVERPAYMENT RECOVERY PROCEDURE**

When a claims overpayment is discovered, BCBSTX will notify the provider. If a provider is notified by BCBSTX of an overpayment, or discovers that they have received an overpayment, the provider should return the overpayment to BCBSTX by mailing a check and a copy of the overpayment notification to:

**Blue Cross and Blue Shield of Texas**  
**Attn: Overpayment Recovery**  
PO Box 51422  
Amarillo, TX 79159-1422

**Note:** The address above cannot accept overnight packages. If you are sending an overnight package, please contact Customer Service at 1-877-688-1811.

If you believe that the overpayment was created in error, you should contact BCBSTX in writing. For a claims re-evaluation, send your correspondence to the address indicated on the overpayment notification.
CLAIM STATUS INQUIRY AND FOLLOW UP

Checking Claim Status
You should receive a response from BCBSTX within 30 days of receipt of a clean claim. If the claim contains all required information, BCBSTX enters the claim into BCBSTX’s claims system for processing and sends you a Remittance Advice (RA).

Claim Status Online
You can confirm BCBSTX’s receipt of your claim through the Availity online tool at www.availity.com. Using Availity, you can also view claims status and payment information.

Telephonic Claim Status
You can also confirm that BCBSTX received your claim by calling Customer Service at 1-877-688-1811. Hours are Monday - Friday, 8 a.m. to 8 p.m. (Central Standard Time), except certain holidays.

Claim Follow Up/Resubmission
You can initiate follow-up action to determine claim status if there has been no response from BCBSTX to a submitted claim after 30 days from the date the clean claim was submitted.

To follow up on a claim, you should:

• Check www.availity.com for disposition of the claim. Please note that the IVR accepts either your billing National Provider Identifier (NPI) or your federal Tax Identification Number (TIN) for provider identification. Should the system not accept your billing NPI or Federal TIN, the system will route your call to a Customer Service representative who will help you with your query. For purposes of assisting you, we may ask you for your TIN.
• Contact Customer Service at 1-877-688-1811
• Provide a copy of the original claim submission and all supporting documentation (such as records and reports) that you deem pertinent or that has been requested by BCBSTX to:

Blue Cross and Blue Shield of Texas
Attn: Complaints and Appeals
PO Box 27838
Albuquerque, NM 87125-7838
Reviewing Batch Status Reports (EDI Claims Only)
If you submitted your claim electronically, you should receive and confirm the contents of BCBSTX Batch Status Reports from your electronic vendor/clearinghouse and correct any errors. Errors must be promptly corrected and resubmitted (electronically) to prevent denials due to untimely filing.

Questions about Claim Status and Follow-up
BCBSTX’s Customer Service is available to answer any questions and provide further instructions regarding claim follow up. A Customer Service representative can:
• Research the status of claims.
• Advise you of necessary follow-up action, if any.

CLAIM PAYMENT APPEAL PROCEDURE
Claim Payment Appeals is the process by which a provider may challenge the disposition of a claim that has already been adjudicated. Provider appeals include, but are not limited to:
• Payer allowance
• Medical policy or medical necessity
• Incorrect payment/coding rules applied

Provider appeals are not considered:
• Corrected claim
• General inquiry/question
• Claim denials needing additional information
• Requests for claim payment appeals must be submitted in writing to BCBSTX within 120 days of a claim disposition. Include all pertinent information.

Blue Cross Blue Shield of Texas
Attn: Complaint and Appeal Department
PO Box 27838
Albuquerque, NM 87125-7838
Fax: 1-855-235-1055
Email: GPDTXMedicaidAG@bcbsnm.com

Providers may also submit provider appeals through the Availity online tool at www.availity.com.

Claim payment appeal requests are resolved within 30 days of receipt of written request. After the review is complete, a resolution letter with the details of our decision will be sent to the provider.
If a provider is not satisfied with the outcome of the review conducted through the Provider Appeal Process, additional steps can be taken:

1. Mediation (handled per the BCBSTX physician agreement)
2. Arbitration (handled per the BCBSTX physician agreement)

If the above processes have been exhausted for a STAR Kids claim, the provider may file a complaint with:

**Health and Human Services Commission**
**Managed Care Operations – H320**
P.O. Box 85200
Austin, TX 78708-520

## COMMON REASONS FOR REJECTED AND RETURNED CLAIMS

Many of the claims returned for further information are returned for common billing errors.

<table>
<thead>
<tr>
<th>Problem</th>
<th>Explanation</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s ID Number is Incomplete</td>
<td>BCBSTX provides ID cards to the member in addition to the state ID card. The member’s plan ID number is called the member number and is the same as their medical ID.</td>
<td><strong>Use the member’s ID number from the BCBSTX ID card.</strong> Inclusion of the alpha prefix at the beginning of the member’s nine-digit BCBSTX ID number is encouraged for electronic claims, but not required. We will not reject the claim.</td>
</tr>
<tr>
<td>Duplicate Claim Submission</td>
<td>Overlapping service dates for the same service create a question about duplication. Claim was submitted to BCBSTX twice without additional information for consideration.</td>
<td>List each date of service, line by line on the claim form. Avoid spanning dates, except for inpatient billing. Make sure you read your RAs, CDNs and mailback forms for important claim determination information before resubmitting a claim. Additional information may be needed.</td>
</tr>
<tr>
<td>Authorization Number Missing/Does Not Match Services</td>
<td>The authorization number is missing, or the approved services do not match the services described in the claim.</td>
<td>Confirm that the Authorization Number is provided on the claim form (CMS-1500 Box 24 and CMS-1450 (UB-04) Box 63) and that the approved services match the provided services.</td>
</tr>
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<tr>
<td>Missing Codes for Required Service Categories</td>
<td>Current Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) manuals must be used because changes are made to the codes quarterly or annually. Manuals may be purchased at any technical bookstore, or through the American Medical Association or the Practice Management Information Corporation.</td>
<td>Make sure all services are coded with the correct codes (see lists provided). Check the code books or ask someone in your office who is familiar with coding.</td>
</tr>
<tr>
<td>Unlisted Code for Service</td>
<td>Some procedures or services do not have a code associated with them, so an unlisted procedure code is used.</td>
<td>BCBSTX needs a description of the procedure and medical records when appropriate in order to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice. For clinician administered drugs/injections, the National Drug Code (NDC) number is required.</td>
</tr>
<tr>
<td>By Report Code for Service</td>
<td>Some procedures or services require additional information.</td>
<td>BCBSTX needs a description of the procedure and medical records when appropriate to calculate reimbursement. DME, prosthetic devices, hearing aids or blood products require a manufacturer’s invoice. For drugs/injections, the NDC number is required.</td>
</tr>
<tr>
<td>Unreasonable Numbers Submitted</td>
<td>Unreasonable numbers, such as ‘9999’ may appear in the Service Units fields.</td>
<td>Make sure to check your claim for accuracy before submitting it.</td>
</tr>
<tr>
<td>Submitting Batches of Claims</td>
<td>Stapling claims together can make subsequent claims appear to be attachments, rather than individual claims.</td>
<td>Make sure each individual claim is clearly identified and not stapled to another claim.</td>
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<tr>
<td>Nursing Care</td>
<td>Nursing charges are included in the hospital and outpatient care charges. Nursing charges that are billed separately are considered unbundled charges and are not payable. In addition, BCBSTX will not pay claims using different room rates for the same type of room to adjust for nursing care.</td>
<td>Do not submit bills for nursing charges.</td>
</tr>
<tr>
<td>Hospital Medicare ID</td>
<td>The Medicare ID number is required to process hospital claims at their appropriate contracted rates.</td>
<td>On the CMS-1450 (UB-04) form, hospitals must enter their Medicare ID number in Box 51.</td>
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</tbody>
</table>