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Appendix For Section 4

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Special Billing Guidelines and Procedures

The following instructions generally apply to both the indicated “Block” on the CMS 1500 claim form and the related “field” of the electronic claim record. **If the electronic claim completion procedure differs, it will be explained and marked with a 💻.** If you have questions with electronic claim submission, please call or email the Electronic Data Interchange (EDI) Help Desk at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry. You may also visit Provider Connection at blueshieldca.com/provider and click on the *Claims* section under *Enroll in Electronic Data Interchange*.

Block 1 - 8 – Patient Information

la. Insured's ID number.

Enter the insured subscriber's ID number exactly as it is shown on the Blue Shield Identification (ID) card.

Always include the three-letter alpha-prefix that precedes the identification number on the patient or subscriber's ID card. This will ensure proper eligibility identification of the patient and enable Blue Shield to route out-of-state subscriber claims to the appropriate Blue Cross/Blue Shield Plan.

💻 Consult the system documentation provided by your software vendor to ensure your system can accept and transmit the three-letter alpha prefix in your electronic claims submissions.

Blocks 9 - 9d – If Blue Shield is the Secondary Payor

In addition to the information in Blocks 9 – 9d, the following primary insurance information is required for both paper and electronic claims:

- Amount Allowed
- Amount Applied to Deductible, and/ or
- Amount Paid.

💻 Blue Shield can accept claims electronically when Blue Shield is the secondary payor. Consult your software documentation or vendor to determine if your software package can support submitting secondary insurance claims.

Block 10a - 10c – Patient Condition

💻 Auto or Other Accident (injury) indicator must contain the correct field value in order for Blue Shield to correctly move the Date of Injury from the electronic claim record onto our claims processing system. Consult your software vendor, billing service or clearinghouse to verify they have correctly identified the value for the electronic claim.

Block 14 – Date of Current Illness, Injury or Pregnancy

💻 Date of illness, injury or pregnancy is always a required field on your electronic claim record. However, Blue Shield will move the date information from the electronic record to our claims processing system only if the value(s) in Block l0b or 10c indicate the equivalent of "Y" to Auto or Other Accident. If you are experiencing problems in which Blue Shield is requesting the date of injury on your electronic claim, check with your software vendor, billing service or clearinghouse to verify that they correctly identified these values.

Block 17 – 17b - Referring or Ordering Physician

17. Name of Referring or Ordering Physician or Other Source

Enter as last name, first name.

Note: Physicians rendering services to a Blue Shield POS member who has self-referred must enter the words "self-referral" in this Block for Blue Shield to accurately identify and process the claim under the PPO benefit plan coverage.

Electronic claim record of Referring Physician:

- Last Name Field (Claim Header Record) -Enter “Self-referral”
- First Name Field (Claim Header Record) -Leave Blank

17b. National Provider Identifier (NPI) Number of Referring/Ordering Physician

When possible, enter in this block the NPI of the referring physician. If the NPI is not known, please leave this field blank.

Block 21 - Diagnosis. Sign and Symptom

Enter the diagnosis/condition of the patient by using a current ICD-10-CM code number. Enter up to four 5-digit codes in priority order. The primary diagnosis code must be in the #1 position of Block 21. The secondary diagnosis code must be in the #2 position of Block 21. If more than four codes are listed on a requisition, submit no more than the top four codes.

DO NOT:

1. Use verbal descriptions instead of codes.
2. Truncate ICD-10-CM codes; all codes must be used at their highest level of specificity (assign the fourth or fifth digit sub. classification where it exists to ensure accurate processing).
3. Code in the decimal point.

Blocks 24a - 24j – Detail of Services. Items Rendered

24a. Dates of Service

Enter the month, day and year for each procedure, using the format "MMDDYY." For non-DME and radiation treatment leave "to" date blank - no date ranging.

Durable Medical Equipment & Radiation Treatment Dates: Enter the month, day and year for each procedure, using the format "MMDDYY." Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24d. Procedure, Service or Supply.

Enter the procedure, service, or supply using the most recently published AMA Current Procedural Terminology (CPT) Code or HCFA Common Procedure Coding System (HCPCS) Code. When applicable, also enter the CPT or HCPCS Modifiers and National Drug Code (NDC). Block 24d contains space for up to four modifiers. When more than four modifiers apply, enter Modifier 99 (for multiple modifiers), and then use the "Comments" field (Block 19) to explain the modifiers. When an unlisted procedure is billed (e.g. 43499), a description of the actual service must be provided in Block 19 if electronically-submitted; or, if paper-submitted, the operative report (or radiology, etc.) must be included.

To report bi-lateral procedures the services must be billed on two lines of the submitted claim. For example:

- 19368
- 19368-50

Report anesthesia services using the five-digit American Society of Anesthesiologists (ASA) Coding System, plus the Status Modifier Code (PI through P6). Also submit Anesthesia time in minutes, standard time in Box 24g.

24i. Qualifier for Performing/Rendering Physician and National Provider Identifier (NPI)

Use the shaded area to enter the appropriate qualifier for the non-NPI reported in the shaded area of 24j.

24j. Performing/Rendering Physician Taxonomy Code and National Provider Identifier (NPI)

Enter the provider specialty taxonomy code (in the shaded area) and NPI (in the non-shaded area) for the performing or rendering provider or supplier.

Provider organizations such as medical group practices or clinics must include the rendering provider taxonomy code and the NPI of the rendering provider. Providers who bill as individual practitioners should also include on their claims the rendering provider specialty taxonomy code and the rendering provider NPI.

Note: Claims from group practices submitted without the performing or rendering taxonomy code in Block 24j will be rejected.

Blocks 25 - 33 – Physician or Supplier Billing Information

25. Federal Tax ID Number, EIN or SSN

Enter the provider/supplier Federal Tax ID, Employer Identification Number or Social Security Number as it is shown on Blue Shield's Provider File for the PIN assigned to the physician/supplier of services.

31. Signature of Physician or Supplier Including Degrees or Credentials

Enter as last name, first name of treating physician.

32. Service Facility Location Information

Enter as the name and address of the location where services were rendered.

32a. Service Facility Location National Provider Identifier (NPI)

When possible, enter the service facility NPI.

33. Provider's/Supplier's Billing Name, Address, Zip Code, and Phone Number

Enter the name, address and telephone number to identify the practice location from which the claim is submitted.

33a. Provider's/Supplier's Billing Name National Provider Identifier (NPI)

Enter the billing provider/supplier's NPI.

33b. Rendering Provider's Specialty Taxonomy Code

Enter the taxonomy code of the rendering provider's specialty.

Additional Claims Submission Pointers

To expedite the processing of your claims, here are some additional claims submission pointers:

- When billing for drugs, supplies and equipment, use HCPCS codes. Drug codes also require the NDC be submitted.
- Use the most current ICD-10-CM for coding all diagnoses, including mental disorders.
- Identify diagnoses as precisely as possible. To expedite claim processing, always use four-digit codes, unless there is none in the particular coding category, and add a fifth digit sub-classification code whenever one exists.
- To ensure proper eligibility, obtain a copy of the Subscriber's Blue Shield ID card to verify the correct subscriber name, number and employer group information. You may visit Provider Connection at blueshieldca.com/provider for up-to-date eligibility verification.
- For correct benefit consideration, report same-day services for the same patient on the same claim. If services exceed more than six detail lines, use separate forms. In order to ensure that multiple forms are processed as a single claim, enter “continued” or “Page 1 of 2” in the Total Charges field.

 Blue Shield's processing system allows up to a maximum of 20 detail lines per electronic professional claims.

- Hospitals must submit professional services by professional electronic claim format or on a CMS 1500 claim form. You may no longer bill these services under revenue codes using the hospital's facility NPI on a UB 04 (or successor) claim form. All Blue Shield hospitals must establish a professional NPI to bill for these services.
- Claims for ancillary services (clinical lab, specialty pharmacy and DME/HME) may require additional location information in order to determine the local plan.

  For EDI claims:

  - Loop 2310 837P Referring Provider segment with the NPI in the NM109
  - Loop 2420E 837P Ordering Provider Segments with the NPI in the NM109 including the N3 and N4 address segments if applicable

  For CMS 1500:

  - Block 5 Enter patient’s complete current address and telephone number.
  - Block 17-17a Enter name and NPI of the referring physician.

    Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words “self-referral.”

  - Block 24b For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
  - Block 32 – 32a For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.

Additional Claims Submission Pointers *(cont'd.)*

Blue Shield may require additional documentation to complete the processing of a claim. The documentation should be complete and legible. Types of documentation may include but are not limited to:

1. Operative Reports
2. Emergency Room Reports
3. Consultant Reports
4. Test Records
5. Facility Records
6. NIA Authorization

- On claims for which you normally include more detailed information on the claim line, please contact the EDI Help Desk at (800) 480-1221 to confirm where this information would go in the electronic format.

Ambulance Claims

Ambulance claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Include the additional coding requirements from the ambulance claim guidelines below so claims can be processed accurately. For more information, complete EDI Companion Guides are available on Provider Connection at blueshieldca.com/provider in the *Claims* section. Call the EDI Help Desk at (800) 480-1221 or email EDI_BSC@blueshieldca.com with any questions.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
170	2300	CLM	Claim Information		
172	2300	CLM05	Health Care Service Location Indicator (Place of Service)	41 - land 42 - water	Use for 'type of transport.'
227	2300	REF	Prior Authorization or Referral Number		
227	2300	REF01	Reference Identification Qualifier	G1	Prior authorization qualifier
	2300	REF02	Prior Authorization or Referral Number		911 plus any free form comments/ information up to 26 characters
246	2300	NTE02	Description		Report location to which patient was transported. Include facility name, city and zip code.
247	2300	NTE01	Note Reference Code	ADD	Use in conjunction with NTE02 to identify the purpose of the notes in NTE02
248	2300	CR	Ambulance Transport Information		
249	2300	CR103	Ambulance Transport Code	I, R, T, X	Use for 'transport information.' All values are accepted.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
250	2300	CR106	Quantity		Use to report transport distance.
250	2300	CR109	Description		Free format field. Use to clarify the purpose for the round-trip service.
250	2300	CR110	Description		Free format field. Use to clarify details regarding use of a stretcher during service.
303	2310D	NM1	Service facility location		
304	2310D	NM101	Entity identifier code	77	Service location. Qualifies patient pick-up location.
304	2310D	NM102	Entity Type qualifier	2	Non-person entity qualifier
304	2310D	NM103	Organization name		Name of location where patient was picked-up, e.g., RESIDENCE (up to 35 characters).
307	2310D	N3	Service facility location address		
307	2310D	N301	Address Information		Address of location where patient was picked up
308	2310D	N4	Service facility location city/state/zip code		
308	2310D	N401	City		City in which patient was picked up
309	2310D	N402	State		State in which patient was picked up
309	2310D	N403	Zip Code		Zip code of location where patient was picked up
400	2400	SV1	Professional Service		
404	2400	SV105	Place of Service		Line level place of service value
412	2400	CR1	Ambulance Transport Information		
412	2400	CR1	Ambulance Certification		Line level ambulance information (see page 248-Loop 2300 CR103, CR104, CR106, CR109, and CR110).
488	2400	NTE	Line Note		
488	2400	NTE01	Note Reference Code	ADD	Use in conjunction with NTE02 to identify the purpose of the notes in NTE02.
488	2400	NTE02			Free format field. Use for any additional comments.

Additional Claims Submission Pointers *(cont'd.)*

Drug Requirements - 837 Professional Claims

Home infusion services and drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Please use the following guidelines:

- Report the appropriate J code in the service line of the claim (loop 2400 SV101-1).
- Report date of service in the service line (loop 2400 DTP03).
- Report name of drug in service line notes (loop 2400 NTE-2).
- Use qualifier "N4" for NDC format 5-4-2 (loop 2410 LIN02).
- Report the National Drug Code (Loop 2410 LIN03).
- If the price of the NDC drug reported in LIN03 is different from the charges reported in the SV102, create a CTP segment in loop 2410.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
400	2400	SV101-1	Product/Service ID qualifier	HC	
400	2400	SV101-2	Product/Service ID	HCPC	J codes for home infusion/drugs
435	2400	DTP01	Service line date qualifier	472	Service line date of service
	2400	DTP03	Date time period	DATE	Date, a time, range of dates
472	2400	REF02	Line Item control number	Provider control number	Providers submit these to assist posting the 835 sent back.
488	2400	NTE01	Note reference code	"ADD"	Only "ADD" is acceptable for these claims.
488	2400	NTE02	Description		Name of drug and any pertinent information – up to 80 bytes
AD 73	2410	LIN02	Product/Service ID qualifier	"N4"	National drug format 5-4-2
AD 74	2410	LIN03	Product/Service ID		National drug code
AD 75	2410	CTP03	Drug unit price		Required only if price is different from how it appears in the SV102. Price per unit of product, service, commodity, etc.
AD 75	2410	CTP04	Quantity		National drug unit count
AD 75	2410	CTP05	Composite unit of measure		Unit or basis of measurement
AD 75	2410	CTP05-1	Unit or basis of measurement code	F2-International Unit GR-Gram ML-Milliliter UN-Unit	Include the appropriate qualifier.
AD 77	2410	REF02	Pharmacy prescription number		Required if the drug has been dispensed with an assigned RX number.

Additional Claims Submission Pointers *(cont'd.)*

837 Institutional Claims

Home infusion services and drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

- Report name of the drug in the claim note (loop 2300 NTE02 – note: use "MED" in NTE01).
- Report description using up to 80 bytes, placed in order of the service lines (see example below).
- Report HCPC code of drug at the service line (loop 2400 SV202-2 (use "HC" in SV202-1).
- Report date of service in the service line (loop 2400 DTP03). Use "472" in DTP01.
- Use qualifier "N4" for NDC format 5-4-2 (loop 2410 LIN02).
- Report the national drug code (loop 2410 LIN03).
- If the price of the NDC drug reported in LIN03 is different from the charges reported in the SV203, create a CTP segment in loop 2410.
- Refer institutional addenda for reference (pages 38-39).
- Report the quantity of drug dispensed (loop 20140 CTP04).
- Report the appropriate drug unit quantity qualifier (loop 2010 CT05-1).

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
207	2300	NTE01	Note reference code	"MED"	Medications
207	2300	NTE02	Description		Name of drugs. Use up to 80 bytes and show in order of service lines. Following is an example: (NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).
446	2400	SV202-1	Product/Service ID qualifier	"HC"	HCPC's code qualifier
447	2400	SV202-2	Product/service		Service code
456	2400	DTP01	Service line date qualifier	"472"	Service line date of service
456	2400	DTP03	Date time period		Date, a time, or range of dates
AD37	2410	LIN02	Product/service ID qualifier	"N4"	National drug format 5-4-2
AD38	2410	CTP03	Unit price		Required only if the price is different from how it appears in SV102. Price per unit of product, service, commodity, etc.
AD38	2410	CP04	Quantity		National drug unit count
AD38	2410	CTP05	Composite unit of measure		Unit or basis of measurement
AD38	2410	CTP05-1	Unit or basis of measurement code	F2-Int'l Unit GR-Gram ML-Milliliter UN-Unit	Include the appropriate qualifier.
AD77	2410	REF02	Pharmacy prescription number		Required if the drug has been dispensed with an assigned RX number

Additional Claims Submission Pointers *(cont'd.)*

HEDIS® Guidelines

Each HEDIS measure identified below has criteria that is required for your patient's chart or claims review to be considered valid towards HEDIS measurement. In addition to using CPT/HCPC codes, please use CPT Category II codes to help your office to meet criteria for HEDIS measures:

Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests	3044F
HbA1c Tests	3045F
HbA1c Tests	3046F
LDL-C Tests	3048F
LDL-C Tests	3049F
LDL-C Tests	3050F

Comprehensive Diabetes Care	
Test or Biometric Value	**CPT Category II Code**
Diabetic Retinal Screening Negative	3072F
Diabetic Retinal Screening With Eye Care Professional	2022F
Diabetic Retinal Screening With Eye Care Professional	2024F
Diabetic Retinal Screening With Eye Care Professional	2026F
Diastolic 80-89	3079F
Diastolic Greater Than/Equal to 90	3080F
Diastolic Less Than 80	3078F
HbA1c Level 7.0-9.0	3045F
HbA1c Level Greater Than 9.0	3046F
HbA1c Level Less Than 7.0	3044F
HbA1c Tests	3044F
HbA1c Tests	3045F
HbA1c Tests	3046F
Nephropathy Treatment	3066F
Nephropathy Treatment	4010F
Systolic Greater Than/Equal to 140	3077F
Systolic Less Than 140	3074F
Systolic Less Than 140	3075F
Urine Protein Tests	3060F
Urine Protein Tests	3061F
Urine Protein Tests	3062F

Care for Older Adults	
Test or Biometric Value	**CPT Category II Code**
Advance Care Planning	1157F
Advance Care Planning	1158F
Functional Status Assessment	1170F
Medication List	1159F
Medication Review	1160F
Pain Assessment	1125F
Pain Assessment	1126F

Frequency of Ongoing Prenatal Care	
Test or Biometric Value	**CPT Category II Code**
Stand Alone Prenatal Visits	0500F
Stand Alone Prenatal Visits	0501F
Stand Alone Prenatal Visits	0502F

Medication Reconciliation Post-Discharge	
Test or Biometric Value	**CPT Category II Code**
Medication Reconciliation	1111F
Postpartum Visits	0503F

Prenatal and Postpartum Care	
Test or Biometric Value	**CPT Category II Code**
Stand Alone Prenatal Visits	0500F
Stand Alone Prenatal Visits	0501F
Stand Alone Prenatal Visits	0502F

Cardiovascular Monitoring for People With Cardiovascular Disease	
Test or Biometric Value	**CPT Category II Code**
LDL-C Tests	3048F
LDL-C Tests	3049F
LDL-C Tests	3050F

Diabetes Monitoring for People With Diabetes and Schizophrenia	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests	3044F
HbA1c Tests	3045F
HbA1c Tests	3046F
LDL-C Tests	3048F
LDL-C Tests	3049F
LDL-C Tests	3050F

Diabetes Screening for People With Schizophrenia or Bipolar Disorder	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests	3044F
HbA1c Tests	3045F
HbA1c Tests	3046F

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Submitting Claims/Encounters Electronically and Electronic Payments

Blue Shield's Electronic Data Interchange (EDI) program enables the paperless exchange of information between Blue Shield, providers, and other business partners. All EDI transactions follow HIPAA-compliant guidelines for format and code. Improved cash flow through quicker receipt of claims, improved efficiencies through less paperwork, and enhanced accuracy of data are just a few of the benefits EDI offers.

Electronic Claim Submission – Providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Electronic Funds Transfer (EFT) – Providers are required to receive claims payments electronically through direct deposit of funds into a designated bank account based on information submitted by the provider.

Electronic Remittance Advice (ERA) – Providers are required to receive ERA files or view Explanation of Payment (EOP) using Blue Shield's Provider Connection website at blueshieldca.com/provider.

Electronically-transmitted claims and payments are more secure, efficient, and cost-effective than paper remittance; they help to reduce revenue cycle times and are environmentally friendly. Providers are required to have an internet connection for all electronic transactions.

EDI Claims (837)

- Reduce your accounts receivable days outstanding. EDI claims arrive the same day the data is transmitted and 99.1 percent process in less than 6 days
- Reduce errors and rebilling; more than 85 percent of EDI claims accepted require no human intervention to adjudicate
- Save money when you eliminate paper, postage and handling costs
- Tighten your revenue management using the quick-response alerts you'll receive on rejected EDI claims

Claims are submitted in the ASC X12 837 5010 format. Blue Shield has contracted with several vendors for providers to submit claims at no cost.

To enroll in electronic claim submission, providers can us any approved clearinghouse listed on Provider Connection. Provider can submit claim at no charge using vendors Office Ally, TriZetto Provider Solutions or Ability Network. These vendors can be contacted at blueshieldca.com/provider in the *Claims* section under *How to Submit Claims* or by contacting the EDI Department at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.

Submitting Claims/Encounters Electronically and Electronic Payments *(cont'd.)*

EDI Claims Status Inquiries (276)

Providers use the EDI Claim Status Inquiry transaction (EDI 276) to inquire about the status of a claim after it has been submitted to Blue Shield. The claim status response transaction (EDI 277) is then returned in response to a request inquiry about the status of a claim. The claim status response (EDI 277) indicates if a claim is pending or finalized. If finalized, it states the disposition of the claim – rejected, denied, approved for payment, or paid.

If the claim was approved or paid, payment date, amount, etc. may also be provided in the 277. If the claim was denied or rejected, the 277 includes an explanation, such as if the subscriber is not eligible.

Benefits of using EDI Claim Inquiry are:

- Increase efficiency by tracking claims in seconds eliminating unnecessary claims tracing
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce accounts receivable days outstanding by receiving responses the next business day

To enroll for the EDI Claim Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange*, contact the EDI Department at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry

Improve Security of PHI and Financial Information

EDI Eligibility Inquiries (270/271)

The EDI Eligibility and Benefit inquiry (EDI 270/271) is used to verify information about the healthcare eligibility and benefits associated with a subscriber or dependent. The eligibility and benefit response (EDI 271):

- Checks member eligibility and benefits within seconds
- Provides correct member demographic information
- Verifies member liability and accumulated amounts including copays, deductibles, and out-of-pocket expenses
- Confirms member coordination of benefits (COB) information

Advantages of checking member eligibility and benefits are:

- Fewer rejected claims
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce collection and billing costs

To enroll for the EDI Eligibility Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or contact the EDI Department at (800) 480-1221.

Improve Security of PHI and Financial Information *(cont'd.)*

EDI Authorizations (278)

Blue Shield offers health care providers the ability to submit request for prior authorization, (e.g., preapproval, preauthorization, prior notification, etc.) review, and receive responses electronically.

This allows the provider to:

- Track records more easily when you receive documentation of authorization requests
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce the potential for patient care delays associated with prior authorization

To enroll for EDI Authorizations, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or contact the EDI Department at (800) 480-1221.

Electronic Remittance Advice (ERA) 835

- Save administrative costs – automate the payment posting process
- Reconcile transactions more quickly
- Reduce payment posting errors
- Reduce paper handling and storage costs
- Convert paper remittance to a single electronic format for your account receivable system

ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format. The ERA replaces the paper Explanation of Payment (EOP). To enroll for the ERA, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or by contacting the EDI Department at (800) 480-1221.

Electronic Funds Transfer (EFT)

- Get faster payment and reduce administrative time and cost with direct deposits into specified accounts
- Increase security of payments – eliminate lost checks
- Get more accurate banking audit results – consult with your financial institution regarding available options

EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. Providers are required to receive claims payments electronically. The EFT process is set up to ensure privacy in addition to being quick and efficient. To enroll for EFT, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange*, contact the EDI Department at (800) 480-1221, or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.

Methods for Direct Transmission of HIPAA-Compliant Transactions

Secure File Transfer Protocol (SFTP)

- Use it for all HIPAA transactions, claims/encounters, ERA, eligibility, claim status, authorizations
- Receive a detailed report the same or next business day
- Support unattended scripted file transfers
- Use robust data exchange capability for larger file size and faster data transfer

Real-time HTTP/s Connectivity

Blue Shield supports CORE Phase II HTTP/s open connectivity standards, HTTP MIME Multipart and SOAP+WSDL for EDI eligibility and claim inquiries.

Blue Shield, in accordance with HIPAA regulation, accepts electronic claims submitted in the ANSI format version 5010. The "Special Billing Guidelines and Procedures" instructions in Appendix 4 apply to both the identified "block" on the CMS 1500 and the related "field" on the electronic record, unless otherwise indicated. Your electronic claims software may have additional specific requirements. Follow the system documentation provided by your software vendor.

The creation of the National Provider Identifier (NPI) was mandated by HIPAA and is an attempt to ensure that all medical providers can be identified by a single identifier across all payor systems. To implement the NPI, Blue Shield cross-references the NPI to the correct provider records in our system. On the CMS 1500 Form, the National Provider Identifier would be noted in Box 33A. Providers should have applied for and received their type 1 and/or type 2 National Provider Identifier through the CMS NPPES website and be submitting that information on all claims. The NPI should also be registered with Blue Shield prior to submitting claims.

Special Billing Situations

Ambulance

Providers are required to submit ambulance claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. By using the coding requirements for the ANSI format, you have the ability to provide Blue Shield with the required information normally obtained from trip notes and additional reports. Within the electronic format you will need to provide the information specific to emergency transports by using a variety of the fields available, including the notes section using the 2300 loop within the REF02 segment. The detailed billing requirements are available on Provider Connection at blueshieldca.com/provider.

Providers needing to schedule ambulance services should go to Provider Connection at blueshieldca.com/provider and click on *Ancillary Providers* in the *Helpful Resources* section on the right to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.

Special Billing Situations *(cont'd.)*

Ancillary Claims Filing Requirements

Submit ancillary claims electronically using instructions below. The referring/ordering physician is required to identify the local plan.

- Loop 2310 837P = Referring Provider segment with the NPI in the NM109.
- Loop 2420E 837P = Ordering Provider Segments with the NPI in the NM109 including the N3 and N4 address segments, if applicable.

Submit Self-Referred Claims Electronically

When Point of Service (POS) plan members self-refer to a specialist, use the instructions below to bill electronically. For questions, contact your clearinghouse or billing system vendor, contact the EDI Department at (800) 480-1221 or email EDI_BSC@blueshieldca.com.

Submitting Self-Referral for POS Professional & Institutional Claims

- Self-Referral for Professional is identified in Loop 2310A
- Self-Referral for Institutional is identified in Loop 2310F
- Insert SELRREFERRAL for NM103 but leave blank NM104
- Use generic NPI for NM109

  Sample: SELFREFERRAL

  NM1*DN*1*SELFREFERRAL*****xx*1002233777~

Reporting NDC Codes on X12N EDI

Professional and Institutional Claims and Encounters

Home Infusion Professional Claims

Home infusion services and drug claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Use the following guidelines:

- Report name of the drug in the claim note (Loop 2300 NTE02). Use "MED" in NTE01.
- Report description using up to 80 bytes, placed in order of the service lines (See example below).
- Report HCPCS code of drug at the service line (Loop 2400 SV202-2). Use "HC" in SV202-1.
- Report date of service in the service line (Loop 2400 DTP03). Use "472" in DTP01.
- Use qualifier "N4" for NDC format 5-4-2 (Loop 2410 LIN02).
- Report the national drug code (Loop 2410 LIN03).

Special Billing Situations *(cont'd.)*

Home Infusion Professional Claims *(cont'd.)*

Notes:

207 2300 NTE01 Note reference - "MED" is Medications.

207 2300 NTE02 Description - Name of drugs. Use up to 80 bytes, and show in order of service lines.

Example:

(NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).

A new field is available in 5010 for description of services that can be used for drug specifics or any additional information needed for the claim. The NTE segment can also still be utilized.

Examples:

Professional Claim / SV102-7

SV1*HC>J3490>>>>>MULTITRACE-4 10ml Conc.*11.94*UN*1.000***1~

Submit Prior Authorization Numbers Electronically

For both Institutional and Professional EDI claims, report Prior Authorization Number in the REF02 segment in Loop 2300. Use the "G1" qualifier in the REF01 segment of Loop 2300.

REF01 = G1

REF02 = Authorization Number

Sample: REF*G1*12456789ABCD

Report the entity that approved the authorization (Blue Shield, IPA, NIA), authorization date, date range service approved, and approved days/units in NTE02 Loop 2300. For Professional claims, use the "Claim Note" and for Institutional claims, use the "Billing Note." In both Professional and Institutional claims, use "ADD" as the value in NTE01.

Sample: NTE*ADD* BSC 20050719 20050719 20050722 4 DAYS

- The first field is either BSC, IPA, or NIA
- The second field is the date the authorization was given (use ccyymmdd format)
- The third field is the date range approved (use ccyymmdd format)
- The fourth field is either the amount of days approved or units

For additional information or specifics on billing claims electronically for secondary and tertiary insurance, drugs, or home infusion, please contact the EDI Department at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.

Special Billing Situations *(cont'd.)*

Submit Corrected Claims Electronically

Corrected claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please wait for the original claim to finalize before sending a corrected claim to avoid denial as a duplicate.

Once the initial has finalized in our system, re-submit the corrected claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on your adjusted claim:

- Send "F8" in REF01 (Loop 2300)
- Send 12 or 14 digit number BSC ICN of incorrect original claim in REF02 (Loop 2300)
- Sample: REF*F8*12345678912345~

Note: 12345678912345 should be replaced with the original claim's Blue Shield of California internal control number (ICN).

You can obtain the Blue Shield claim number using the claim status option on Provider Connection or from the explanation of benefits (EOB) or electronic remittance advice (ERA).

Additional Reports

For providers that are submitting to Blue Shield in the ANSI 5010 format they will also receive reports that are specific to the 837 claims transaction.

Interchange Acknowledgment – TA1 – Provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Functional Acknowledgment – 999 – Identifies the acceptance or rejection of the functional group, transaction sets or segments.

Unsolicitated Claim Status Inquiry Report 277CA) v 5010 – Blue Shield validates inbound electronic data interchange (EDI) for HIPAA compliance, advising only of HIPAA level rejections.

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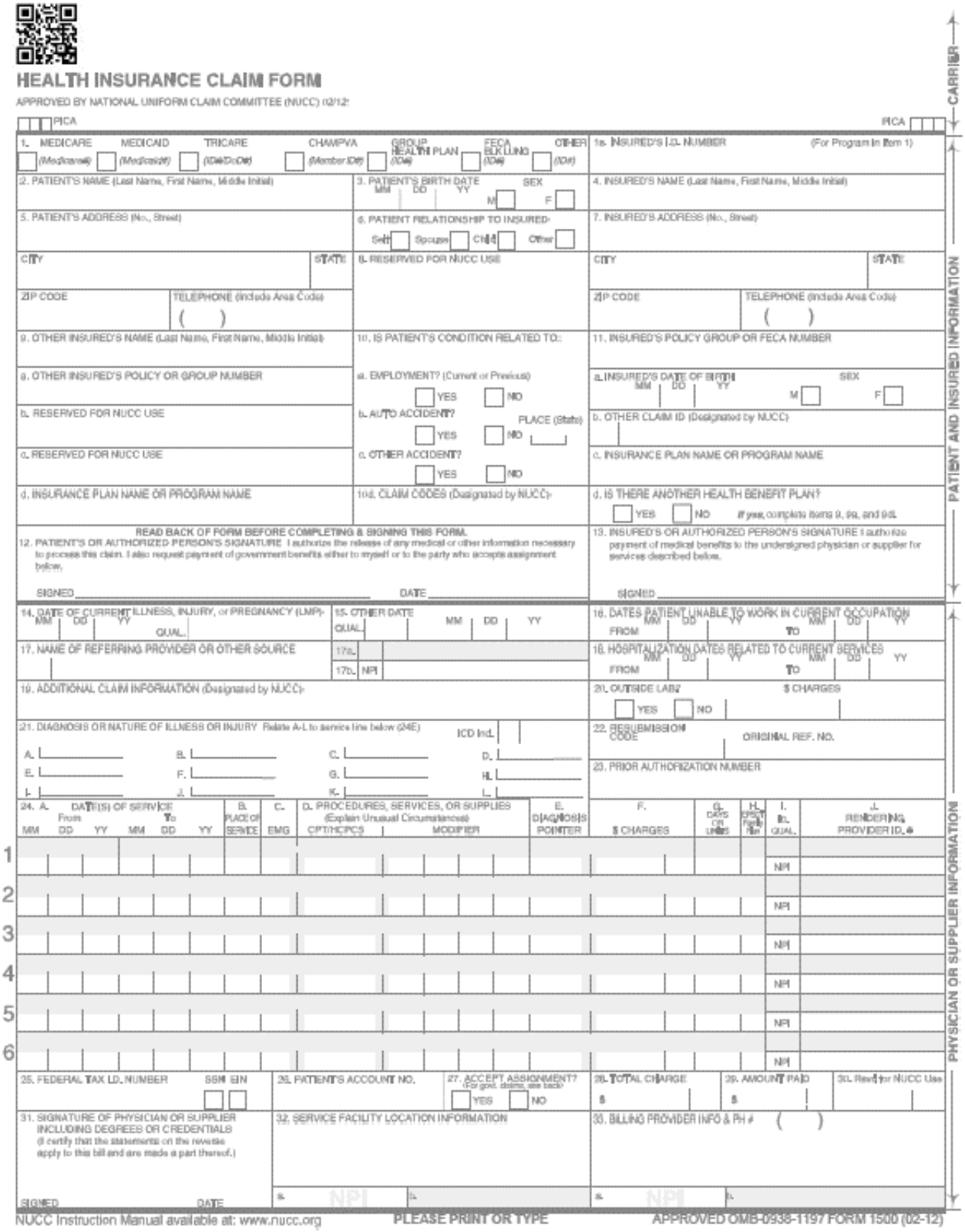
Sample CMS 1500 Form



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Sample CMS 1500 Form

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Instructions for Completing a CMS 1500 Form

Block #	Instructions
1	Identify coverage by checking all appropriate boxes.
1a	Enter the subscriber's ID number exactly as on ID card, including the first three alpha characters.
2	Enter patient's full name in last name, first name, middle initial order.
3	Enter patient's date of birth (two-digit method, e.g., 05/07/42) and sex.
4	Enter name of insured subscriber exactly as it appears on the ID card.
5	Enter patient's complete current address and telephone number.
6	Enter patient's relationship to insured subscriber.
7	Enter insured subscriber's complete address and telephone number.
8	Check appropriate box.
9	If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the insured person's name; and
9a	Policy and/or group number; and
9b	Date of birth and sex; and
9c	Employer's name, if applicable; and
9d	Insurance plan or program name.
10a-c	Check “Yes” or “No” to indicate whether employment, auto or other accident applies to one or more service described in Block 24.
11	Enter subscriber's group number exactly as it appears on ID card; and
11a	Insured's date of birth and sex; and
11b	Employer's name, if applicable; and
11c	Insurance plan or program code; and
11d	Indicate if there is another health benefit plan. If ‘Yes,’ complete fields 9-9d with other health benefit plan information.
12-13	Not applicable. *Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals.*
14	Enter date of current illness, injury, or pregnancy.
15	Complete if applicable.
16	If applicable, enter dates patient is/has been unable to work. An entry in this field usually indicates workers' compensation related coverage.
17-17b	Enter name and NPI of the referring physician. *Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words “self-referral.”*
18	Complete these dates when a medical service is furnished as a result of, or subsequent to, a related hospitalization.
19	Enter taxonomy codes and appropriate qualifier (ZZ). *Note: When you need to use more than four modifiers with a procedure code, enter the additional modifiers.*
20	Enter “Yes” or “No” when billing diagnostic laboratory tests. “No” means the tests were performed by the billing physician/lab. “Yes” means the lab test was performed outside the physician’s office. (A lab billing for test performed by another affiliated lab should also check “Yes”). If “Yes”, you must enter purchase price for the test in the “Charges” portion of this block. When lab procedures are performed by a party other than the billing physician/lab, identify procedures by adding the -90 modifier to the regular procedure code in Block 24D. Charges for these services cannot exceed the amount the outside laboratory charged.
21	Enter up to four 5-digit ICD-10 CM codes in priority order with the primary diagnosis in the #1 position. Do <u>not</u> add any diagnosis description.
22-23	Not applicable.

24 Itemize each service rendered using the appropriate codes. Report only one service per line. This area of the claim form may not contain more than six lines of service. If you need to report more lines for the same patient, do so on separate claims. Also, claims cannot be continued from one to another; each claim must be separate.

24a Enter the month, day, and year for each procedure, using the format "MMDDYY." For non-DME and radiation treatment leave 'to' date blank - no date ranging.
Durable Medical Equipment & Radiation Treatment Dates: Enter the month, day, and year for each procedure using the format "MMDDYY." Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24b Enter the two-digit Place of Service code. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
Refer to the Medicare website www.cms.gov for current place of services.

24c Leave blank. Completion of this block is not required.

24d Enter procedure, service or supply using the appropriate HCPCS/CPT procedure code and up to four modifiers. For assistant at surgery or anesthesia, always be sure to include applicable modifiers. For Telehealth HIPAA compliant video services, use Modifier 95 in 24d and place of service 02 in 24b.
Note: When you need to use more than four modifiers with a procedure code, enter Modifier 99 in Block 24D and list applicable modifiers in Block 19.

24e Enter diagnosis code reference pointer from Block 21 to relate date of service and procedures performed to appropriate diagnosis. A maximum of 4 diagnosis pointers may be referenced. Place commas between multiple diagnosis reference pointers on the same line.

24f Enter charge for the service performed. Do not enter dollar signs or decimal points. Always include cents.

24g When a charge is for more than one item or service, enter number of items or services. This field is most commonly used for number of miles, units of supplies, anesthesia minutes, or oxygen volume.

Format: This is a three-digit block. The rightmost digit represents tenths, and the leftmost 2 digits represent whole items or units.

Example: 1 Service - Enter 010
2.5 Services - Enter 025
14 Services - Enter 140

If you need to report more than 99 services, you must use two lines.

Example: 100 Services billed. Enter first line as 990 and second line as 010.

For anesthesia services, show elapsed time in minutes. Do not use time 'units'.

Example: 1 hour and 10 minutes = 70 minutes. Enter as 070 (70 minutes).

24h Not applicable.

24j Enter the provider specialty Taxonomy Code (in the shaded area) and NPI (in the non-shaded area) for the performing or rendering provider or supplier.

Provider organizations such as medical group practices or clinics must include the rendering provider taxonomy code and the NPI of the rendering provider. Providers who bill as individual practitioners should also include on their claims the rendering provider specialty taxonomy code and the rendering provider NPI.

Note: Claims from group practices submitted without the rendering specialty taxonomy code in Block 24j will be rejected.

	Enter provider specialty taxonomy code and NPI of the rendering provider or supplier. Several different providers or suppliers may be involved in providing services billed on the claim. If several members of a group shown in Block 33 have furnished services, this item is used to distinguish them.
25	Show provider/supplier Federal Tax ID (Employer Identification Number) or Social Security Number.
26	Enter the patient's account number.
27	Blue Shield will make direct payment to Physician Members and Participating Health Care Professional only, whether or not this box is completed.
28	Enter total charge for services indicated in Block 24F. Do not enter dollar signs or decimal points. Always include cents.
29	Enter total amount paid by patient on submitted charges in Block 28.
30	Enter the balance due (Block 28 1ess Block 29).
31	Show signature of provider/supplier or representative and the date form was signed.
32 – 32b	Enter name and address of person, organization or facility performing services, if services were furnished in a hospital, clinic, laboratory or any facility other than patient's home or provider's office. Enter the NPI in box 32a. For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented or purchased at a retail store.
33 – 33b	Enter Provider's/Supplier's Billing name, address, telephone number for which bill is submitted. Enter the billing provider / supplier's NPI in box 33a. Enter the Rendering Providers specialty taxonomy code in 33b.

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Guidelines for Successful ICR Processing

Follow the guidelines below to assure successful Intelligent Character Recognition (ICR) entry of CMS 1500 paper claims.

- Use only original CMS 1500 claim forms printed in *"red dropout"* ink. The ink used to print the form must not contain any carbon.

- Use the same font and the same entry method on the entire form. Use Pica, Arial 10, 11, or 12 font type; black ink; and input data in CAPITAL letters. Mixing entry methods (e.g., adding typewritten information to a claim already printed on a laser printer) may impede processing.

- Left justify information in each box and keep data from touching box edges or running outside of numbered boxes.

- Keep claims clean, free of smudges or discolored erasure marks. You may use white correction tape but not correction liquids because ICR can read through them. If you use correction tape, be certain any printing on it is blemish-free.

- The service area of the claim form (Blocks 24a-24j) must be no more than six lines per claim. If you need to submit more than six lines of services for one patient, use separate forms.

  Note: Enter "continued" in the Total Charges field on the first claim to ensure it is processed as a single claim.

- Use the proper units of service in Block 24g. If units are not used, the claim may default to 1 unit during processing, or the claim may be returned to you for more information.

- Enter appropriate ICD-10 codes in the diagnosis (Block 21) or the CPT and Modifier codes in service line (Blocks 24a-24j) areas. Comments or narrative descriptions of procedures, modifiers, or diagnosis codes will require claims to be manually entered into our processing system.

- Attachments cannot be read via ICR but will be reviewed by a claims specialist. To ensure attachments can be read and understood, they must be 8.5 by 11 inches and should be produced in clean, readable printing in dark ink, preferably on white paper.

Guidelines for Successful ICR Processing

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Where to Send Claims

Providers are required to submit claims electronically that do not have a record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Using Electronic Data Interchange (EDI), providers submit claims and receive payments electronically for faster processing and payment. EDI allows paperless billing and payment for healthcare services and supplies and automates many types of routine inquiries. Please contact the EDI Help Desk at (800) 480-1221 or email edi_bsc@blueshieldca.com with any questions about EDI.

If you still need to submit paper claims, use the Claims Routing Tool, located on Provider Connection at blueshieldca.com/provider under the *Claims* tab, to determine the correct mailing address for each member. Because claims mailing addresses are different for different Blue Plan members, using the Claims Routing Tool is the most accurate way to determine a claims mailing address.

If you are unable to access the Claims Routing Tool, please use the specific P.O. Box numbers listed on this page. If the subscriber's group is not listed, use the **All Other Blue Shield Plans** P.O. Box number shown below.

BLUECARD OUT-OF-AREA PROGRAM
Check subscriber ID for three-letter prefix before sending
Blue Shield of California
BlueCard Program
P. O. Box 1505
Red Bluff, CA 96080-1505
(800) 622-0632

CALPERS
(California Public Employees Retirement System)
Blue Shield of California
CalPERS
P. O. Box 272540
Chico, CA 95927-2540
(800) 541-6652

FEDERAL EMPLOYEE PROGRAM (FEP)
Subscriber ID number begins with the letter"R"
FEP
P.O. Box 272510
Chico, CA 95927-2510
(800) 824-8839

NATIONAL ACCOUNTS - NASCO
Subscriber number should be submitted with the 3-digit alpha prefix
Blue Shield of California
NASCO
P. O. Box 272570
Chico, CA 95927-2570
(800) 241-4896

MEDICARE/BLUE SHIELD 65 PLUS (HMO)SM
Blue Shield 65 Plus
P. O. Box 272640
Chico, CA 95927
(800) 541-6652
Fax (818) 228-5104

INITIAL PROVIDER APPEAL AND RESOLUTION
Blue Shield of California
P. O. Box 272620
Chico, CA 95927-2620

FINAL PROVIDER APPEAL AND RESOLUTION
Blue Shield of California
P.O. Box 629011
El Dorado Hills, CA 95762-9011

SHORT-TERM CLAIMS FOR BLUE SHIELD LIFE & HEALTH INSURANCE COMPANY
P. O. Box 9000
London, KY 40742

ALL OTHER BLUE SHIELD PLANS
Blue Shield of California
P. O. Box 272540
Chico, CA 95927-2540
(800) 541-6652

Where to Send Claims for Foundations for Medical Care

When the name of a medical foundation appears on a subscriber's identification card, the benefits for that subscriber are administered by that foundation. Forward all claims to that foundation for payment.

The medical foundations with which Blue Shield is affiliated are listed below:

Foundation for Medical Care of Tulare & Kings Counties, Inc.

Address: 3335 South Fairway
Visalia, CA 93277
Phone: **(800) 662-5502**
(559) 734-1321
Fax: (559) 334-0081 (Primary)
(559) 734-3828

Foundation for Medical Care of Mendocino-Lake Counties

Address: 620 S. Dora St., Suite 201
Ukiah, CA 95482-5482
Phone: **(707) 462-7607**
Fax: (707) 462-1206

Blue Shield Payment Processing Logic

The following provides a high-level, general overview of Blue Shield's payment processing logic. Please refer to Provider Connection at blueshieldca.com/provider under the *Claims* tab for the full payment policies. Please call Provider Information & Enrollment at (800) 258-3091 for additional information.

Blue Shield Claim Edits and Industry Standard Correct Coding

Blue Shield utilizes claims editing software that uses correct coding from industry standard sources, such as Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and health plan-developed policies, as applicable, during the claims adjudication process. Additional sources may be used as defined in the Claim Editing Payment Policy.

The claims editing software is also able to identify previously submitted historical claims that are related to current claim submissions, which may result in adjustments to claims previously processed.

Claims editing software will be updated periodically, without notification, to reflect the addition of newly released/revised/deleted codes and their associated claim edits, including but not limited to NCCI revisions, and health plan payment policies.

Manual Claim Review

There are numerous situations in which claims may undergo a manual review. When this takes place, the clinical documentation is compared to the submitted claims. If documentation does not support the codes submitted, the codes may be changed to reflect the documentation. If the submitted code is modified or changed after a manual claim review, the EOB message will further define the change.

Prescreen Claims

Blue Shield provides web access to Clear Claim Connection, a tool that enables providers to prospectively prescreen claims. Access and training instructions for Clear Claim Connection can be found on Provider Connection at blueshieldca.com/provider under *Claims, Policies and Guidelines*, then *Payment Policies and Rules.*

Professional and Ancillary Provider Payment Policies

Blue Shield has adopted payment policies for licensed and certified healthcare professional and ancillary provider types. Blue Shield Payment Policies are updated periodically to reflect the addition of newly released/revised/deleted codes without notification and can be found on Provider Connection at blueshieldca.com/provider under the *Claims* tab.

Blue Shield Payment Processing Logic

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List of Office-Based Ambulatory Procedures

CPT	DESCRIPTION
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11100	Biopsy, skin lesion
11101	Biopsy, skin add-on
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)

CPT	DESCRIPTION
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst
20615	Treatment of bone cyst
20950	Fluid pressure, muscle

List of Office-Based Ambulatory Procedures

CPT	DESCRIPTION
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast
29010	Application of body cast
29015	Application of body cast
29035	Application of body cast

CPT	DESCRIPTION
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast
29740	Wedging of cast
29750	Wedging of clubfoot cast

List of Office-Based Ambulatory Procedures

CPT	DESCRIPTION
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
44705	Prepare fecal microbiota
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure
51100	Drain bladder by needle
51700	Irrigation of bladder
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study

CPT	DESCRIPTION
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
59020	Fetal contract stress test
59025	Fetal non-stress test
59050	Fetal monitor w/report
59051	Fetal monitor/interpret only
59200	Insert cervical dilator
59412	Antepartum manipulation
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital

List of Office-Based Ambulatory Procedures

CPT	DESCRIPTION
64445	N block inj, sciatic, sng
64455	N block inj, plantar digit
64550	Apply neurostimulator
64611	Chemodenerv saliv glands
64615	Chemodenerv musc migraine
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle larynx EMG
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas

CPT	DESCRIPTION
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0190T	Place intraoc radiation src
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0228T	Njx tfrml eprl w/us cer/thor
0230T	Njx tfrml eprl w/us lumb/sac
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0295T	Ext ecg complete
0296T	Ext ecg recording
0297T	Ext ecg scan w/report
0298T	Ext ecg review and interp
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rpt
0379T	Vis Field assmnt tech suppt
0380T	Comp animat ret imag series
0419T	Dstrj Neurofibroma Xtnsv
0420T	Dstrj Neurofibroma Xtnsv
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0482T	Absolute quant myocardial bld flow
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record