BlueCross BlueShield of Texas

Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠ Provider Manual – Filing Claims - Electronic Filing

Please Note

Throughout this provider manual there will be instances when there are references unique to **Blue Essentials, Blue Advantage HMO, Blue Premier** and **MyBlue Health**. These specific requirements will be noted with the plan/network name. If a Plan/network name is not specifically listed or "**Plan**" is referenced, the information will apply to **all** HMO products.

In this Section, The following topics are covered in this section:

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Paperless Claims Processing Overview

Electronic Data Interchange (EDI) refers to the process of submitting claims data electronically. This is sometimes referred to as "paperless" claims processing.

Using an automated claim filing system gives you more control over claims filed and is the first step in making your office paper-free. BCBSTX providers can submit claims through Availity or their preferred vendor.

Availity Overview

Availity optimizes the flow of information between health care professionals, health plans, and other health care stakeholders through a secure internet-based exchange.The Availity Essentials encompasses administrative and clinical services, supports both real-time and batch transactions via the web and electronic data interchange (EDI), and is Health Insurance Portability and Accountability Act (HIPAA) compliant.

For more information, including an online demonstration, visit availity.com or call **1-800-AVAILITY (282-4548)**.

Electronic Remittance Advice (ERA)

BCBSTX can provide you with an Electronic Remittance Advice (ERA). ERAs are produced every weekday and include all claims (whether submitted on paper or electronically). This process allows you to automatically post payments to your patients' accounts.

If you are interested in this service, please contact your computer vendor to determine if they have the capability to process ERAs and if so, what format and the version they support.

BCBSTX offers the ERA in the following formats and versions:

- **ANSI 835 version 5010 A1**

You can enroll for 835 ERA delivery via the Availity portal. For enrollment assistance, refer to the Electronic Commerce/EFT/ERA page of our website. To obtain the specifications for receiving ERAs, refer to the BCBSTX EFT & ERA Enrollment User Guide. For further assistance, email Electronic Commerce Services or refer to Electronic Commerce on the provider website.

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Electronic Funds Transfer (EFT)

Electronic Funds Transfer (EFT) is a form of direct deposit that allows the transfer of BCBSTX payments directly to a health care provider's designated bank account. EFT is identical to other direct deposit operations such as paycheck deposits and can speed the reimbursement process. EFT payments are made every weekday.

Adding the EFT capability can help you streamline your administrative processes. ***Electronic Funds Transfer is the fastest way an insurance company can pay a claim.***

You can enroll for 835 EFT delivery via the Availity portal. For enrollment assistance, refer to the Electronic Commerce/EFT/ERA page of our website. If you need further information information regarding EFT, refer to the BCBSTX EFT & ERA Enrollment User Guide. For additional assistance, email Electronic Commerce Services or look under Electronic Commerce on the provider website.

Electronic Payment Summary (EPS)

Electronic Payment Summary (EPS) is an electronic print image of the Provider Claim Summary (PCS). It provides the same payment information as the paper PCS. It is sent the same day as your ERA. The paper PCS is discontinued 31 days after the provider enrolls in ERA.

Electronic Claim Submission & Payer Response Report

To ensure that electronic claims are received for processing, health care providers should review their Payer Response Reports after each transmission.

To obtain the specifications on the Payer Response Reports options available to you, please contact your clearinghouse. If you are an Availity customer, contact Availity Client Services at **1-800-AVAILITY (282-4548)** or review their EDI Companion Guide.

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Payer Response Reports

BCBSTX supplies Payer Response Reports to our Electronic Data Interchange (EDI) Partners from the BCBS claims processing systems to submitters of electronic BCBSTX claims. This report contains an individual **Document Control Number (DCN)** in the "Payer ICN" field of the response for each claim accepted. The report is forwarded within 48 hours after transmission is received and can be used as proof of claim receipt within our claims processing system for **Plan** claims.

The DCN is significant in that electronic claims can now be traced back to the actual claim received into our claims processing system. An example of a DCN number is 60745D26102X. The first four digits of the DCN indicate the date: 6 (year=2016), 074 (Julian date=March 15). The final digit of the number "X" indicates an electronic claim.

You may see "Informational/Warning" messages on these reports. These messages are generated by the claim application; but no action is necessary at this time. The claim will either be processed or you will receive a letter notifying you the claim must be resubmitted.

System Implications

The Document Control Number information and the detailed Payer Response Reports provide accepted and rejected claims and give health care providers the tools they need to track their BCBSTX electronic claims.

If a claim should be rejected, you will need to correct the error(s) and resubmit the claim electronically for processing. To ensure faster turnaround time and efficiency, BCBSTX recommends that your software have the capability to electronically retransmit individually rejected claims.

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What are the Benefits of Electronic Medical Claims (EMC)/ Electronic Data Interchange (EDI)?

- Turnaround time is faster for **Plan** claims that are complete and accurate, and you are reimbursed more quickly, improving your cash flow. Claims filed with incomplete or incorrect information will either be rejected or suspended for further action.
- Your mailing and administrative costs are significantly reduced.
- Fewer claims are returned for information, saving your staff time and effort.
- Up-front claims editing reduces returned claims.
- You have more control of claims filed electronically. The data you submit electronically is imported into our claims processing system— there is no need for intermediate data entry.
- Make sure all corrected/replacement claims are refiled **electronically** with BCBSTX.
- You can transmit claims to our EDI Partners 24 hours a day, seven days a week.
- For support relating to electronic claims submission and/or other transactions available with Availity, please contact Availity Client Services at **800-AVAILITY (282-4548)**.
- The patient's account number appears on every Explanation of Payment you receive, which expedites posting of payment information.

Payer Identification Code

Plan health care providers submitting claims via the Availity Health Information Network must use payer identification code 84980. If you use another clearinghouse, please confirm that the correct electronic payer identifier for BCBSTX is used with your electronic claim vendor.

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What Claims Can be Filed Electronically?

All BCBSTX claims including:

- Out-of-state
- **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health** *(including Encounters for **Blue Essentials** only)*
- Blue Cross and Blue Shield secondary claims
- Corrected and replacement claims
- All claim types may be filed electronically

Availity Authorizations and Referrals Confirmation Number

If the **Plan** members need to be referred are referred to a specialty care physician or professional provider or the service requires prior authorization by BCBSTX Utilization Management, these requests can be submitted via the Availity's Authorizations & Referrals tool or by calling the Utilization Management Department. The Availity Authorizations & Referrals' confirmation number must be entered on an electronic or paper claim.

Electronic submission — Enter the authorization number in REF 2300 - Prior Authorization, REF01=G1, REF02=Prior Authorization number.

Paper submission – enter the authorization number in Block 23 on the **CMS-1500** (02/12) Claim Form.

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How Does Electronic Claim Filing Work?

There are several ways to submit your claims data electronically:

- You may submit ALL claims directly to Availity. This network is designed to be easily integrated into the software system typically used by all providers. A list of approved software vendors can be obtained by contacting the Availity Client Services **1-800-AVAILITY (282-4548)** or by visiting the Availity website at availity.com.
- You can submit BCBSTX claims through most major electronic clearinghouses.
- You may work through a software vendor who can provide the level of system management support you need for your practice, or you may choose to submit claims through a clearinghouse.
- You may choose to have a billing agent or service submit claims on your behalf.

Submit Secondary Claims Electronically

Plan secondary claims can be submitted electronically. To do so requires NO explanation of benefits; however, all prior payer payment information must be included in the appropriate loops and segments and the electronic claim submitted to BCBSTX. All **Plan** rules for referral notification and prior authorization/precertification requirements must be followed.

Duplicate Claims Filing is Costly

In many instances, we find that the original claim was submitted electronically and the receipt was confirmed as accepted. Physicians or professional providers who have an automatic follow up procedure should not generate a paper or electronic "tracer" prior to 30 days after the original claim was filed. It is important to realize that submitting a duplicate tracer claim on paper or electronically will not improve the processing time. This acts only to delay processing, as the follow-up claim will be rejected as "a duplicate of a claim already in process".

Note: For information regarding Blue Cross Medicare Advantage electronic claim rejections, refer to the Blue Cross Medicare Advantage (HMO)SM Supplement.

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Submit Encounter Data Electronically	**Plan** claims and encounter data can be submitted electronically by following a few simple guidelines. On the next page are the specific data elements, which are required to process **Plan** claim/encounter submission data

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Submit Encounter Data Electronically, cont.

Extended NSF	ANSI		
(AA∅-04.∅)	BHTO6 or BHTO7	=	'RP' designates Encounter data only. All other values will be handled as claims
(AA∅-18.∅)	NM109(40) position 1	=	G
Payer ID (AA∅-17. ∅)	NM109(40) Positions 2-6	=	84980
Plan Route Code (DA∅-18.∅)	NM109 (IL/QC) positions 1-2	=	"ZGA" (First 3 positions) Not Required
Member Number (DA∅-18.∅)	NM109 (IL/QC Positions 3-13	=	11 digits Example: 123456789-02 (Enter the member number exactly as it appears on the Member ID card)
Blue Essentials Group Number (DA∅-10.∅)	SBR03	=	Indicated on the ID card
Blue Shield Provider Number (BA∅-∅2. ∅) and 14.∅)	PRV03(B1)	=	BCBSTX 6-digit ID number
Blue Shield Rendering Provider Number (FA∅-23. ∅) Required on Group Practices only	NM109(82)	=	BCBSTX 6-digit number in 8XXXXX format
Prior Authorization Number (DA∅-14. ∅∅-14. ∅	REF02(GI)	=	Requires entry of "On Call" for On Call Physician/Provider
Specialty Care Physicians/Providers (DA∅-14. ∅	REF02(GI)	=	Authorization Number

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Providers with Multiple Specialties

If you have obtained a unique Organization ***(Type 2) National Provider Identifier (*NPI)** number for each specialty, you should bill with the appropriate Individual ***(Type 1***)and Organization ***(Type 2)*** NPI number combination accordingly.

In the absence of a unique Organization ***(Type 2)*** NPI number for each specialty, you are strongly encouraged to include the applicable taxonomy code* in your claims submission. Taxonomy codes play a critical role in the claims payment process for providers practicing in more than one specialty. Electronic claims transactions accommodate the entry of taxonomy codes and will assist BCBSTX in selecting the appropriate provider record during the claims adjudication process. For assistance in billing the taxonomy code in claim transactions, refer to your practice management software and/or clearinghouse guides.

**The health care provider taxonomy code set is a comprehensive listing of unique 10-character alphanumeric codes. The code set is structured into 3 levels - provider type, classification, and area of specialization - to enable individual, group or institutional providers to identify their specialty category or categories in HIPAA transactions. The entire code set can be found on the Washington Publishing Company (WPC) website. The health care provider taxonomy code set levels are organized to allow drilling down to a provider's most specific level of specialization*