
Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

September 8, 2000

S-12-00

INSIDE THIS ISSUE:

- Getting Your Claims to Pay Faster

ATTACHMENTS:

- "Patient Financial Responsibility Statement" Form

QUESTIONS:

Contact your Professional Relations Representative, or the Professional Relations Hotline at 1.800.432.3587, or in the Topeka area, 785.291.7060.

OUR WEB ADDRESS:

<http://www.bcbsks.com>

ACKNOWLEDGEMENT:

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Published by your
Professional Relations
Department

GETTING YOUR CLAIMS TO PAY FASTER

In an effort to assist you and your office staff with claims filing, we have written this newsletter to identify what is required in each of the sections of the HCFA 1500 claim form. Errors in these fields can cause claims to be delayed in processing.

PAPERLESS CLAIMS (ELECTRONIC MEDIA CLAIMS)

- If your office is not currently submitting paperless claims or is not utilizing the system for most of your claims, we encourage you to do so.
- Submission of paperless claims decreases the turnaround time for cash flow and helps eliminate delays in processing.
- Submission of paperless claims also provides you the opportunity to utilize electronic remittance advices; thus cutting your time spent posting.
- If you should want to contact us about submitting paperless claims the telephone number is:

ASK, Inc. 1-800-472-6481 ext. 7135 Topeka (785) 291-7135
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Sent to: CAP, ASC, HAD, LPN, OOD, RN excluding DDS & Oral Surge

PROVIDER NUMBERS

All claims must have a valid provider number. The following outlines the correct method of indicating your provider number on the HCFA 1500 claim form in Box 24K and/or Box 33. It also defines the use of Box 32.

BOX 24K ♦ RESERVED FOR LOCAL USE

- This box is used to identify the individual performing provider when they are practicing in a multiple provider office, if the office has been assigned a common pay provider number.
- If everyone in your office receives their reimbursement from us on one check, you have what we call a common pay or group provider number.
- The provider number of the individual performing the service is entered, on the line with their service, in Box 24K.
- The common pay provider number is entered in Box 33, of the claim form, following "GRP #".
- In a common pay provider number situation, it is possible that each line of service could have a different individual performing provider number in Box 24K.

Box 24 K should look like this, if billing for individual providers with a common pay provider number in Box 33:

K
RESERVED FOR LOCAL USE
012345
012345
067890
012345
034567
034567

• **Box 24K does not apply to the following provider types:**

- Ambulance
- Ambulatory Surgery Centers
- Doctors who are in solo practice and only have one provider number for a particular location
- Doctors who are in multiple provider practices but their BCBSKS checks come to them separately
- HME Suppliers
- Hearing Aid Dispensers
- Independent Laboratories
- Licensed Practical Nurses who are in solo practice
- Licensed Practical Nurses who are in multiple provider practices but their BCBSKS checks come to them separately
- Opticians
- Outpatient Substance Abuse Facilities
- Registered Nurses who in solo practice
- Registered Nurses who are in multiple provider practices but their BCBSKS checks come to them separately
- Sleep laboratories.

In this case the provider number goes in Box 33, following "PIN #" and Box 24 K is left blank.

- **BOX 32 ♦ NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED**

This box should be completed if the service was rendered in a facility other than the office or the patient's home.

- Box 32 should look like this:

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

Lab America
131 Pershing Way
Their Town, MD 88883

- **BOX 33 ♦ PHYSICIAN'S/SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND TELEPHONE NUMBER**

- You should always give your complete name and address as it appears on our records.
- There are four ways this box may be used relative to the provider number(s):
 1. Individual numbers where there is only one doctor/provider in the practice.
 2. The provider is a business, as in the case of an ambulance or hearing aid dispenser.
 3. Individual numbers where there is more than one doctor/provider in a practice but their reimbursement comes on separate checks.
 4. Multiple doctors/providers in a practice and their reimbursement comes on one check.

- Box 33 should look like this for the first three examples:

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

DR. JOE SMITH
1133 ANYROAD
THAT TOWN, KS 66666
(316) 555-5555

PIN# 000001

| GRP #

- Box 3 should look like this for the last example:

33. PHYSICIAN'S SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

ANYTIME CLINIC
1133 THAT ROADWAY
MYTOWN, KS 66668
(316) 555-5554

PIN# 000001

| GRP #

PATIENT IDENTIFICATION

Always use the PREFIX and COMPLETE NUMBER, and NAME exactly as they appear on the card.

EXAMPLES

OGX123456789 BCN987654321 R12345678

Elizabeth A. Smith rather than Betty A. Smith

PLACE OF SERVICE

Please refer to the table below for the appropriate place of service codes.

24B PLACE OF SERVICE CODES			
11	Office	42	Ambulance - Air or Water
12	Patient's Home	51	Inpatient Psychiatric Facility
21	Inpatient Hospital	52	Psychiatric Facility Partial Hospitalization
22	Outpatient Hospital	53	Community Mental Health Center
23	Emergency Room	54	Intermediate Care Facility/Mentally Retarded
24	Ambulatory Surgical Center	55	Residential Substance Abuse Treatment Facility
25	Birthing Center	56	Psychiatric Residential Treatment Center
26	Military Treatment Center	61	Comprehensive Inpatient Rehabilitation Facility
31	Skilled nursing Facility	62	Comprehensive Outpatient Rehabilitation Facility
32	Nursing Facility	65	End Stage Renal Disease Treatment Facility
33	Custodial Care Facility	71	State or Local Public Health Clinic
34	Hospice	72	Rural Health Clinic
41	Ambulance-Land	81	Independent Laboratory

PCP REFERRALS - Patient Financial Responsibility Statement

Make sure you acknowledge the number of visits and the services that have been authorized prior to performing any services. Those services not authorized could result in a provider write-off or increased patient's responsibility.

Services not included in the referral are contracting provider write-offs. If a patient signed "financial Responsibility Form" (copy attached) and is submitted with the claim, the services will be made the patient's financial responsibility. This form is only valid if it is completed and signed by the patient prior to the rendering or delivery of the service or item.

If there are questions concerning the services authorized, you should direct your questions to the PCP prior to the service(s) being rendered.

UNLISTED PROCEDURES

Any procedure code that is non-specific in its nomenclature must have a definition in Box 19.

EXAMPLES

97139 Unlisted therapeutic procedure (specify) Without specific information the claim will be returned for the information.

99070 Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list).

Without specific information the service will be made content of service and could result in a provider write-off.

(See Newsletter S-13-00, for more specific information)

TWO DIFFERENT INSURANCE POLICIES

When a patient is covered by two different insurance policies, Box 9 of the HCFA 1500 claim form must be completed in its entirety. The information in Box 9 should be for the secondary carrier.

TYPE OF SERVICE

Please refer to the table below for the appropriate type of service codes.

24C TYPE OF SERVICE CODES (OPTIONAL)			
1	Medical Care	F	Ambulatory Surgical Center
2	Surgery	H	Hospice
3	Consultation	K	Maternity
4	Diagnostic X-ray PC/TC	L	Renal Supplies in Home
5	Diagnostic Laboratory PC/TC	M	Alternate Payment For Maintenance Dialysis
6	Radiation Therapy	N	Kidney Donor
7	Anesthesia	R	Drugs
8	Assistant at Surgery	V	Pneumococcal Vaccine
9	Other Medical Surgery	W	HME Rental
0	Blood or Packed Red Cells	X	HME Purchase (New)
A	HME Purchase (Used)	Y	Second Opinion On Elective Surgery
B	Dental	Z	Third Opinion On Elective Surgery
C	(Maternity) Conductive Anesthesia		

UNIT(S) OF SERVICE

If more than one unit of service was performed, you should complete Box 24G of the HCFA 1500 claim form. Box 24 G is a 3-digit field. When the units are days of service, the units must match the date span indicated. Following is a chart with non-all-inclusive examples:

Service Performed	Number of services provided	Units Field
Anesthesia minutes	125	125
Ambulance loaded miles	100	100
Eye glass lenses of the same power	2	002
Hearing aids	2	002
Ostomy bags	Box of 24	024
Modality	30 minutes and code is per 15 minute increments	002
Occupational therapy	Subsequent 30 minutes code is per 15 minute increments	002
Repair prosthetic	2 hours	002

For more specific information relative to a particular code, please refer to previous newsletters. You may also contact us with questions. Our names and numbers are listed at the end of the newsletter.

ACCIDENT CODING

Please remember that the insured/member contracts define accident as:

"Accidental injury means an injury to your body caused solely through external, violent and accidental means. 'Accidental injury' does not include accidental injuries that occur before the date from which you have had continuous coverage with the Company; disease or infection (unless it's pus-producing infection that occurred from an accidental cut or wound); hernia; injuries caused by biting or chewing."

We have expanded the above definition to include sprain and strains.

Following are examples of accident coding:

CORRECT ACCIDENT CODING

		10. IS PATIENTS'S CONDITION RELATED TO A. EMPLOYMENT? (CURRENT OR PREVIOUS) [] YES <input checked="" type="checkbox"/> NO B. AUTO ACCIDENT? Place (state) [] YES <input checked="" type="checkbox"/> NO /_____/
		C. OTHER ACCIDENT? <input checked="" type="checkbox"/> YES [] NO
		10d. RESERVED FOR LOCAL USE
11. 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: _____
14. DATE OF CURRENT ILLNESS (First Symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY 06 / 15 / 00	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY / /	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17A. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE Patient fell off of porch at own home		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)		
1. / 844.00	3. / _____.	
2. / 722.2	4. / _____.	

BOX 10: Marked yes

BOX 14: Accident date given

BOX 19: Complete description of accident and exactly where it happened given

BOX 21: Accident diagnosis used as primary diagnosis (800 through 999.99) given

CORRECT ACCIDENT CODING

		10. IS PATIENTS'S CONDITION RELATED TO A. EMPLOYMENT? (CURRENT OR PREVIOUS) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO B. AUTO ACCIDENT? Place (state) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO /_____/
		C. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		10d. RESERVED FOR LOCAL USE
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: _____
14. DATE OF CURRENT ILLNESS (First Symptom) OR MM DD YY INJURY (Accident) OR 06 / 15 / 00 PREGNANCY (LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY / /	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17A. I.D. NUMBER OF REFERRING PHYSICIAN	
19. RESERVED FOR LOCAL USE Barrel fell on head at work. Worker's Compensation denial information attached.		
11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3, OR 4 TO ITEM 24E BY LINE)		
1. / 850.0	3. / _____.	_____
2. / _____.	4. / _____.	_____

BOX 10: Marked yes

BOX 14: Accident date given

BOX 19: Complete description of accident and exactly where it happened given

BOX 19: Other insurance payment/denial information attached

BOX 21: Accident diagnosis used as primary diagnosis (800 through 999.99) given.

If you should have questions concerning the information in this newsletter please contact one of the following:

Professional Relations Representatives	Location	Phone Number
Professional Relations Hotline	Topeka	1-800-432-3587
Sherian Conwell	Topeka	1-800-432-0216 ext. 8738 (785) 291-8738
Sue Dunaway	Topeka	1-800-432-0216 ext. 8207 (785) 291-8207
Velda Fresquez-Gray	Wichita	1-800-432-0216 ext. 1674 (316) 269-1674
Denny Hartman	Wichita	1-800-432-0216 ext. 1674 (316) 269-1674
Cheri Iarossi	Topeka	1-800-432-0216 ext. 8651 (785) 291-8651
Vikki Lindemuth	Topeka	1-800-432-0216 ext. 7878 (785) 291-7878
Debra Meisenheimer	Hutchinson	(316) 663-1313
Pat Toda	Topeka	1-800-432-0216 ext. 8716 (785) 291-8716

◆Blue Select◆
 ◆Premier Blue◆
 ◆Premier Blue* -Access Option◆
 ◆Premier Blue* Self-Referral Option◆
PATIENT FINANCIAL RESPONSIBILITY STATEMENT
 To be used when services are not referred by the PCP

SERVICE(S) WITHOUT A PCP REFERRAL

I understand that my health care services through Blue Select or Premier Blue must be authorized by my PCP for them to be covered at all (Premier Blue) or covered at the highest level of benefit (Blue Select, Premier Blue Self-Referral Option).

I either do not have a PCP referral or the referral does not include this service.

**BLUE SELECT
PREMIER BLUE SELF-REFERRAL OPTION**

I am choosing to self-refer for the service(s) and understand they will be allowed at that benefit level, if covered under my contract.

PREMIER BLUE

I am choosing to have the service(s) and understand that I do not have a referral from my PCP for the service(s). I agree that I am financially liable for this expense.

SERVICE(S) BY A NON-CONTRACTING PREMIER BLUE-ACCESS OPTION PROVIDER WHO IS CAP CONTRACTING

PREMIER BLUE ACCESS OPTION

I am choosing to have the service(s) performed by a non-Premier Blue Access Option provider who is a CAP provider. I understand that I will have a greater financial responsibility.

.....

I hereby authorize _____
(PLEASE PRINT OR TYPE: PROVIDER NAME AND PROVIDER NUMBER)

to bill me for any expenses that may not actually be paid by Blue Select or Premier Blue for a/an:

_____ (PLEASE PRINT OR TYPE: PROCEDURE CODE(S) PLUS BRIEF NARRATIVE)

to be performed on _____, which I understand will cost approximately \$_____.

Member/Insured Signature: _____ Date: _____

Member/Insured Name: _____

Insurance ID: # _____

*Independent Licensee of the Blue Cross and Blue Shield Association