

# **Filing Claims**

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Physicians, other health care professionals, and facilities participating with Regence BlueCross BlueShield of Utah (Regence BCBSU) agree to bill us directly for covered services provided to members. Once coverage through Regence has been verified, members should not be asked for payment at the time of service except for deductible, copayment and/or coinsurance amounts not collected and non-covered services.

## **Timely Filing Requirements**

All original claims for covered services performed for a member must be received by their health plan no later than twelve (12) months from the date services were rendered.

## **Use Your Identification Number**

All electronically submitted claims must include the National Provider Identifier (NPI) along with the required tax identification number. Until further notice an electronically submitted claim may also include the appropriate Regence BCBSU provider identification number.

The NPI is not required for paper claim submissions, though we strongly recommend you apply for and use an NPI. Paper claim submissions can continue to be submitted using the Regence BCBSU provider identifier with or without an NPI. If you are unsure of your provider identification number, please contact your provider consultant.

## **Claim Filing Procedures**

Providers may submit claim forms by the following methods:

- a. Submit claims electronically through our Electronic Data Interchange (EDI). You may contact the EDI Support Center at (801) 333-2900 or toll free 1(888) 344-5583 for questions, or for assistance in getting this function established for your practice.
- b. Submit paper claim forms using the most current *CMS-1500* or *UB-04* claim form for medical claims to:

Regence BCBSU  
P.O. Box 30272  
Salt Lake City, UT 84130-0272

# Filing Claims Electronically

Electronic billing through the Utah Health Information Network (UHIN) or Office Ally is available for all Regence BCBSU and BlueCard® out-of-area claims. Electronic claims can be prepared by physicians, dentists, other health care professionals, health care facilities or their representatives and processed by Regence in lieu of paper claims. Electronic claims submission offers the following advantages:

- Online real-time editing
- Fewer possibilities for data errors
- Automated claims payment for clean claims
- Detailed online submission and error reports
- Single submission point for all electronic claims
- Faster claims turnaround time, improving cash flow
- Reduction of administrative costs (no postage or paper forms to purchase)
- No per-claim submission charge for Regence claims to if you submit directly through UHIN or Office Ally.

You can submit electronic claims through many types of practice management software via modem, using direct data entry via the Internet, or by making arrangements with a software vendor, billing service or clearinghouse of your choice. Technical specifications and information about how to get started submitting electronic transactions are available on our *Provider Web Site* in the Claims & Billing section, under Electronic Transactions.

To find out more information about submitting claims electronically to UHIN, go to the UHIN Web site at [www.uhin.com](http://www.uhin.com) and click on the "Getting Started" link or contact the Electronic Data Interchange (EDI) Support Desk at (801) 333-2900 or toll free 1(888) 344-5583. For information about submitting claims through Office Ally, go to [www.officeally.com](http://www.officeally.com) or contact them via email at [info@officeally.com](mailto:info@officeally.com) or by phone at (949) 464-9129.

## Electronic claims reminders for current electronic submitters

If you already submit claims electronically, please read the following reminders:

- Always enter the patient's information exactly as it appears on their member card. This will help avoid misrouting and processing delays.
- All claims for out-of-area members with alpha prefixes can and should be billed electronically to expedite their processing.
- The transmittal acceptance report (transaction 997) verifies only that your transmission was received. It does not verify the accuracy of the claims you submitted. Be sure to frequently check your New error (transaction 277FE) and Unformatted error (transaction 864) reports to ensure any errors found in your claims are quickly addressed.  
*Note: If any errors are detected in any of your claims during transmittal, the entire batch will be rejected, not just the claim in question.*
- Only claims for Medicare adjustments should be billed on paper.

## Other electronic transactions

You may utilize electronic transactions to accomplish much more than just claims submission. You may submit multiple inquiries at once and expect an electronic response within 1-2 minutes. Making use of the following transactions can save your office much of the time currently spent on research, thus freeing your staff to perform the more critical needs of practice management.

### Common X12 Transactions

148 – First report of injury	277FE – New error report
169 – Payer to payer COB verification	278 – Authorizations, Referrals Request/Response/ Notification/Inquiry
270 – Eligibility request	834 – Enrollment
271 – Eligibility response	835 – Claim Payment/Remittance
275 – Attachment	837 – Claim or Encounter
276 – Claim status inquiry	864 – Unformatted Error Report
277 – Claim status response/Request for additional information.	997 – Acknowledgement

Each of these transactions must be separately set up in your system to enable their functionality. Please consult with your practice management vendor to have these transactions enabled. If you have any additional questions, please contact the EDI Support Desk at (801) 333-2900 or toll free 1(888) 344-5583; or you may e-mail them at: [edihelpdesk@regence.com](mailto:edihelpdesk@regence.com). For information regarding electronic funds transfer (EFT), please call 1(800) 662-7534.

## Paper claim forms

Regence requires paper claims to be submitted on an original, standard *CMS 1500 (08/05)* (professional claims) or *UB-04* (facility claims) claim form. A sample of each form is given on the next pages, followed by instructions for completing these forms. Once received, paper claims are scanned and converted into electronic images that are viewed and processed online by our claims analysts. Please observe the following guidelines to ensure your claims are successfully imaged:

- Key or type all information onto your claims. Handwriting and stamps are not always dark or legible enough to be captured by our imaging equipment.  
*Note:* The Centers for Medicare & Medicaid Services (CMS) no longer accept signature stamps.
- Do not use highlighters on your claims. The imaging equipment 'blacks out' the portions of your claims that are highlighted, making the information unreadable.

## Where to send original paper claims

Regence BlueCross BlueShield of Utah  
Attn: Claims Processing  
P.O. Box 30272  
Salt Lake City, UT 84130-0272

## Where to send other correspondence

Regence BlueCross BlueShield of Utah  
P.O. Box 30270  
Salt Lake City, UT 84130-0270

## CMS-1500 Claim Form Instructions

To complete this form, follow the instructions below. **Each field on the form has a corresponding number. Claims submitted with missing or invalid required fields may be rejected and/or returned for correction and resubmission.**

Requirements	Field	Description
	1:	<b>Type of Health Insurance</b> Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
<b>Required</b>	<b>1A:</b>	<b>Insured's Identification Number</b> Enter the three-digit alpha prefix and identification number of the insured <i>exactly as shown on the member card</i> .
<b>Required</b>	<b>2:</b>	<b>Patient's Name</b> Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the member card. <i>Do not use nicknames</i> .
<b>Required</b>	<b>3:</b>	<b>Patient's Birth Date and Sex</b> Enter the eight-digit month, day, century, and year of the patient's birth (MMDDCCYY). Check the appropriate box to identify patient's gender.
<b>Required</b>	<b>4:</b>	<b>Insured's Name</b> Enter the last name, first name, and middle initial of the insured as shown on the member card. If the patient is the insured, enter the word "same".
<b>Required</b>	<b>5:</b>	<b>Patient's Address</b> Enter the patient's complete address.
<b>Required</b>	<b>6:</b>	<b>Patient's Relationship to Insured</b> Check self, spouse, child or other.
	7:	Insured's Address Complete if the patient <i>is not</i> the insured.
	8:	Patient Status Check the appropriate box.
<b>Recommended</b>	<b>9:</b>	<b>Other Insured's Name</b> Enter the name of the insured with other insurance company.

Requirements	Field	Description
Recommended	9A:	<b>Other Insured's Policy or Group Number</b> Enter the policy and/or group number of the other insurance coverage.
Recommended	9B:	<b>Other Insured's Date of Birth</b> Enter the information available to you in eight-digit format (MMDDCCYY).
	9C:	Employer's Name or School Name Enter the complete name.
	9D:	Insurance Plan Name or Program Name Enter the name of the insurance plan.
Required	10:	<b>Is Patient's Condition Related to</b> Check the correct boxes in a., b. and c.
	10D:	Reserved for Local Use Leave blank.
Required	11:	<b>Insured's Policy or FECA Number</b> Enter the group number of the insured as shown on the member card.  <b>Exception:</b> If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
Recommended	11A:	<b>Insured's Date of Birth</b> Use eight-digit date format if submitting.
	11B:	Employer's Name or School Name
	11C:	Insurance Plan Name or Program Name
	11D:	Additional Benefit Plans
	12:	Patient's or Authorized Person's Signature Have patient sign if your office requires it.
	13:	Insured's or Authorized Person's Signature May be left blank.
Required for accidents or injuries  Recommended for all other	14:	<b>Date of Current illness, Injury, Pregnancy</b> Enter the date of the current illness, injury or pregnancy.
	15:	If Patient has had Same or Similar illness Enter the date the patient first consulted you for this condition.

Requirements	Field	Description
	16:	Dates Patient Unable to Work in Current Occupation Leave blank.
	17:	Name of Referring Provider or Other Source List the name of the referring, ordering or supervising physician or other health care professional.
	17A:	Other ID # Enter the assigned Regence provider number if submitting a paper claim and the physician or other health care professional listed in field 17.
	17B:	NPI # Enter the assigned NPI of the physician or other health care professional listed in field 17 for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
<b>Recommended</b>	<b>18:</b>	<b>Hospitalization Dates Related to Current Services</b>
	19:	Reserved for Local Use Leave blank.
	20:	Outside Lab If your patient had lab work done, check the correct box <i>even if you are not billing for the lab work</i> . Do not list charges in this field.
<b>Required</b>	<b>21:</b>	<b>Diagnosis or Nature of illness or Injury</b> Identify the patient's condition(s) by entering up to four ICD-9-CM codes in order of relevance. <b>Codes must be carried out to the highest possible (4th or 5th) digit. Non-specific diagnoses, such as 780, may result in denials.</b>
	22:	Medicaid Resubmission Leave blank.
	23:	Prior Authorization Number Leave blank.
<b>Recommended</b>	<b>24A:</b>	<b>Shaded Area – National Drug Code (NDC)</b> In the shaded area above "Date(s) of Service", enter the two digit Product ID Qualifier "N4" identifying the type of number being provided. Enter the NDC number after the Product ID Qualifier.
<b>Required</b>	<b>24A:</b>	<b>Date(s) of Service</b> Enter the date(s) of service. If only one service is provided, the date can be entered as a "from date" or a "to date".

Requirements	Field	Description
Required	24B:	<p><b>Place of Services</b></p> <p>Indicate where services were provided by entering the appropriate two-digit place of service code. Valid codes are as follows:</p> <ul style="list-style-type: none"> <li>11 Office</li> <li>12 Home</li> <li>21 Inpatient Hospital</li> <li>22 Outpatient Hospital</li> <li>23 Emergency Room</li> <li>24 Ambulatory Surgery Center</li> <li>25 Birthing Center</li> <li>26 Military Treatment Center</li> <li>31 Skilled Nursing Facility</li> <li>32 Nursing Facility</li> <li>33 Custodial Care Facility</li> <li>34 Hospice</li> <li>41 Ambulance (land)</li> <li>42 Ambulance (air or water)</li> <li>51 Inpatient Psychiatric Facility</li> <li>52 Psychiatric Facility Partial Hospitalization</li> <li>53 Community Mental Health Facility</li> <li>54 Intermediate Care Facility/Mentally Retarded</li> <li>55 Residential Substance Abuse Treatment Facility</li> <li>56 Psychiatric Residential Treatment Center</li> <li>61 Comprehensive Inpatient Rehabilitation Facility</li> <li>62 Comprehensive Outpatient Rehabilitation Facility</li> <li>65 End-Stage Renal Disease Treatment Facility</li> </ul>
	24C:	<p>Emergency Indicator (EMG)</p> <p>Leave blank.</p>
Recommended	24D:	<p><b>Shaded Area – NDC Unit of Measure and Numeric Quantity Administered</b></p> <p>In the shaded area above “Field 24D Procedures, Services, or Supplies”, enter the two digit NDC Unit of Measurement Qualifier followed by the numeric quantity administered to the patient, which is a full 10-digit number. The 10 digits consist of seven digits for the whole number, followed by the three-digit decimal portion of the number.</p> <p><b>Valid Unit of Measurement Qualifiers are:</b></p> <ul style="list-style-type: none"> <li>F2 – International unit</li> <li>GR – Gram</li> <li>ML – Milliliter</li> <li>UN – Unit</li> </ul> <p>The HCPCS code should be entered in Field 24D “Procedures, Services, or Supplies”, the charges in Field 24F and the units in Field 24G.</p>

Requirements	Field	Description
Required	24D:	<b>Procedures, Services, or Supplies: CPT/HCPCS, Modifier</b> Enter a valid procedure code best describing each service or supply. Explain unusual services or situations with procedure code modifiers. If a CPT and a HCPCS code describe the same service, use the CPT code. <b>Claims with an invalid or missing procedure code may be denied or returned for correction and resubmission.</b>
Required	24E:	<b>Diagnosis Pointer</b> Enter one diagnosis code reference number per claim line (i.e., up to four ICD-9-CM codes) as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis.
Required	24F:	<b>Charges</b> Enter your charge for each listed service.
Required	24G:	<b>Days or Units</b> Enter the number of services billed on the line. For anesthesia services, report time and modifier units on separate lines.
	24H:	EPSDT Family Plan Leave blank.
Required if applicable	24I:	<b>ID Qualifier</b> If entering an individual Regence provider number in 24J, ID Qualifier Code '1B' is required.
Required if applicable	24J:	<b>Rendering Provider ID # (split field)</b> The individual performing/rendering the service. <b>The rendering provider ID # is required when different than the billing provider found in Field 33.</b> Please submit only one provider per claim.  <b>Unlabeled Field</b> – Enter your individual Regence provider number if submitting paper claim.  <b>NPI Field</b> – Enter your Type 1 individual NPI number for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
Required	25:	<b>Federal Tax ID Number</b> Enter the provider's tax identification number as given by the Internal Revenue Service.
Recommended	26:	<b>Patient's Account Number</b> If you use patient account numbers, enter the number for this patient.
Required for Medicare only	27:	<b>Accept Assignment</b> Please check applicable box.

Requirements	Field	Description
Required	28:	<b>Total Charge</b> Enter the total of all charges submitted on this claim.
Recommended	29:	<b>Amount Paid</b> Enter the exact amount the patient and/or other insurance carrier has paid to you for these services. Entering the words 'patient paid' without indicating the exact amount may cause claims delays and inaccurate processing.
	30:	<b>Balance Due</b> Enter the difference between Field 28 and Field 29.
Required	31:	<b>Signature of Physician or Supplier</b> Sign and date the form. Stamped and preprinted signatures that include the degree are acceptable for all products except Regence MedAdvantage. Claims for this product must be signed or have a preprinted signature including degree.
Required if applicable	32:	<b>Service Facility Location Information</b> Enter name and address of the location where the services were rendered.
Required if applicable	32A:	<b>NPI #</b> Enter the service facility NPI number (Type 2) of the service facility location, if known.
Required if applicable	32B:	<b>Other ID</b> Enter the two digit ID Qualifier '1B' and the service facility Regence provider number of the service facility location if submitting a paper claim.
Required	33:	<b>Billing Provider Information and Phone #</b> Enter the billing provider's name, address, zip code, and telephone number.
Required for electronic claim submissions	33A:	<b>NPI #</b> Enter the NPI number (Type 1 or 2) of the billing provider.  The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
Required for paper claims submissions if not submitting an NPI	33B:	<b>Other ID</b> Enter the two digit ID Qualifier '1B' and the Regence provider number of the billing provider. <b>Other ID is required if submitting a paper claim and 33A does not include an NPI.</b>



# UB-04 Claim Form Instructions

All hospitals that are participating with Regence are required to submit *UB-04* claims in electronic format. Following are instructions for completing a paper *UB-04* claim.

Requirements	Form Locator	Description
Required	1:	<b>Provider Name and Address, and Telephone Number</b> Enter provider's name, address, ZIP code and phone number.
	2:	<b>Pay-to Name, Address, and Secondary Identification Fields</b> Leave blank.
Required	3:	<b>Patient Control Number</b> Enter patient's control number or patient account number.
Required	4:	<b>Type of Bill (TOB)</b> Enter type of bill code. <b>Valid type of bill codes:</b> Hospital – Inpatient                    11X 12X 18X Hospital – Outpatient                    13X 14X Skilled Nursing – Inpatient            21X 22X Skilled Nursing – Outpatient        23X Home Health                                32X 33X 34X Clinic                                         71X 72X 73X 74X 75X 76X 79X Special Facility                         81X 82X 83X 85X  <b>Valid third digit codes:</b> Admit through discharge claim    1 Interim - First claim                    2 Interim - Continuing claim            3 Interim - Last claim                    4 Late charges only claim               5 Replacement of prior claim         7 Void/cancel prior claim               8
Required	5:	<b>Federal Tax Number</b> Enter your federal tax identification number.
Required	6:	<b>Statement Covers Period (From-Through)</b> Enter statement covers from and through date. Must be in MMDDYY format.
	7:	Untitled Not used
Required	8:	<b>Patient's Name</b> Enter patient's last name, first name and middle initial.

<b>Requirements</b>	<b>Form Locator</b>	<b>Description</b>
<b>Required</b>	<b>9:</b>	<b>Patient Address</b> Enter patient's full mailing address including street number, city, state and zip code.
<b>Required</b>	<b>10:</b>	<b>Patient Birth Date</b> Enter patient's date of birth. Must be in MMDDCCYY format.
<b>Required</b>	<b>11:</b>	<b>Patient Sex</b> Enter "M" (male) or "F" (female).
<b>Required</b>	<b>12:</b>	<b>Admission Date</b> Enter date patient is admitted for this stay. Must be in MMDDYY format.
<b>Required for inpatient claims</b>	<b>13:</b>	<b>Admission Hour</b> Enter the admission hour code.  <b>Valid Admission Hour Codes.</b> 00 = 12:00-12:59 midnight      12 = 12:00-12:59 noon 01 = 01:00-01:59                13 = 01:00-01:59 02 = 02:00-02:59                14 = 02:00-02:59 03 = 03:00-03:59                15 = 03:00-03:59 04 = 04:00-04:59                16 = 04:00-04:59 05 = 05:00-05:59                17 = 05:00-05:59 06 = 06:00-06:59                18 = 06:00-06:59 07 = 07:00-07:59                19 = 07:00-07:59 08 = 08:00-08:59                20 = 08:00-08:59 09 = 09:00-09:59                21 = 09:00-09:59 10 = 10:00-10:59                22 = 10:00-10:59 11 = 11:00-11:59                23 = 11:00-11:59 99 = Unknown
<b>Required for inpatient claims</b>	<b>14:</b>	<b>Type of Admission/Visit</b> Enter the type of admission code. This code indicates the priority of this admission.  <b>Valid type of admission codes:</b> 1 = Emergency 2 = Urgent  3 = Elective 4 = Newborn 5 = Trauma Center 9 = Information not available
<b>Required</b>	<b>15:</b>	<b>Point of Origin for Admission or Visit</b> Enter the code indicating the source of the referral for this admission or visit.  <b>Valid source of admission codes:</b> 1 = Non-Health Care Facility 2 = Clinic



Requirements	Form Locator	Description
		43 = Discharged/transferred to a federal health care facility 50 = Discharged/transferred to Hospice – home 51 = Discharged/transferred to Hospice – medical facility 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 62 = Discharges/transferred to <u>an</u> inpatient rehabilitation facility including distinct part units of a “hospital” 63 = Discharge/transferred to long term care hospital 64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 = Discharged/transferred to a Critical Access Hospital
<b>Recommended</b>	<b>18 – 28:</b>	<p><b>Condition Codes</b>            Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. We can only accept up to 10 condition codes.</p> <p><b>Valid Condition Codes</b>            02 = Condition is Employment Related            03 = Patient Covered by Insurance Not Reflected</p> <p>04 = Information Only Bill            05 = Lien Has Been            06 = ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance            07 = Treatment of Non-terminal Condition for Hospice Patient            08 = Beneficiary Would Not Provide Information Concerning Other Insurance Coverage.            09 = Neither Patient Nor Spouse is Employed            10 = Patient and/or Spouse is Employed but no EGHP Coverage            11 = Disabled Beneficiary But no Large Group Health Plan</p> <p><b>12-14 = Payer codes reserved for internal use only by third party payers.</b></p> <p>17 = Patient is Homeless            18 = Maiden Name Retained            19 = Child Retains Mother's Name            20 = Beneficiary Requested            21 = Billing for Denial Notice            26 = VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility            27 = Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test (Sole Community Hospitals only).            28 = Patient and/or Spouse's EGHP is Secondary to Medicare            29 = Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare            30 = Qualifying Clinical Trials</p>

Requirements	Form Locator	Description
		<p><b>Student Status</b>  31 = Patient is a Student (Full-Time - Day)  32 = Patient is a Student (Cooperative/Work Study Program)  33 = Patient is a Student (Full-Time - Night)  34 = Patient is a Student (Part-Time)</p> <p><b>Accommodation</b>  36 = General Care Patient in a Special Unit (Not used by hospitals under PPS)  37 = Ward Accommodation at Patient's Request (Not used by hospitals under PPS.)  38 = Semi-private Room Not Available (Not used by hospitals under PPS)  39 = Private Room Medically Necessary (Not used by hospitals under PPS)  40 = Same Day Transfer  41 = Partial Hospitalization  42 = Continuing Care Not Related to Inpatient Admission  43 = Continuing Care Not Provided Within Prescribed Post Discharge Window  44 = Inpatient Admission Changed to Outpatient  46 = Non-Availability Statement on File  47 = Reserved for TRICARE  48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs)  49 = Product replacement within product</p> <p><b>Skilled Nursing Facility Information</b>  55 = SNF Bed Not Available  56 = Medical Appropriateness  57 = SNF Readmission  58 = Terminated Managed Care Organization Enrollee  59 = Non-primary ESRD Facility  67 = Beneficiary Elects Not to Use Lifetime Reserve (LTR)  69 = IME/DGME/N&amp;A Payment Only</p> <p><b>Renal Dialysis Setting</b>  71 = Full Care in Unit  72 = Self-Care in Unit  73 = Self-Care Training  74 = Home  75 = Home 100-percent  76 = Back-up In-Facility Dialysis  77 = Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full  78 = New Coverage Not Implemented by Managed Care Plan  79 = CORF Services Provided Off-Site  80 = Home Dialysis-Nursing Facility</p>

Requirements	Form Locator	Description
		<p>A9 = Second Opinion Surgery</p> <p>AA = Abortion Performed due to Rape</p> <p>AB = Abortion Performed due to Incest</p> <p>AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality</p> <p>AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself</p> <p>AE = Abortion Performed due to Physical Health of Mother that is not Life Endangering</p> <p>AF = Abortion Performed due to Emotional/psychological Health of the Mother</p> <p>AG = Abortion Performed due to Social Economic Reasons</p> <p>AH = Elective Abortion Self</p> <p>AI = Sterilization Self-explanatory</p> <p>AJ = Payer Responsible for Copayment</p> <p>AK = Air Ambulance</p> <p>AL = Specialized Treatment/bed Unavailable</p> <p>AM = Non-emergency Medically Necessary Stretcher Transport Required</p> <p>AN = Preadmission Screening Not Required</p> <p>B1 = Beneficiary is Ineligible for Demonstration Program</p> <p>B2 = Critical Access Hospital Ambulance Attestation</p> <p>B3 = Pregnancy Indicator</p> <p>B4 = Admission Unrelated to Discharge</p> <p><b>Quality Improvement Organization (QIO)</b></p> <p>C1 = Approved as Billed</p> <p>C3 = Partial Approval</p> <p>C4 = Admission Denied</p> <p>C5 = Post-payment Review Applicable</p> <p>C6 = Preadmission/Pre-procedure</p> <p>C7 = Extended Authorization</p> <p>D0 = Changes to Service Dates</p> <p>D1 = Changes to Charges</p> <p>D2 = Changes to Revenue Codes/HCPCS/HIPPS Rate Code</p> <p>D3 = Second or Subsequent Interim PPS Bill</p> <p>D4 = Changes In ICD-9-CM Diagnosis and/or Procedure Code</p> <p>D5 = Cancel to Correct HICN or Provider ID</p> <p>D6 = Cancel Only to Repay a Duplicate or OIG Overpayment</p> <p>D7 = Change to Make Medicare the Secondary Payer</p> <p>D8 = Change to Make Medicare the Primary Payer</p> <p>D9 = Any Other Change</p> <p>DR = Disaster related</p> <p>E0 = Change in Patient Status</p> <p>G0 = Distinct Medical Visit</p>

Requirements	Form Locator	Description
		H0 = Delayed Filing, Statement Of Intent Submitted
<b>Required for automobile accidents</b>	29	<b>Accident State</b> Two-digit state abbreviation of the state where the accident occurred.
	30	Untitled Not used.
<b>Recommended Required for all accidents</b>	<b>31 – 41:</b>	<p><b>Occurrence Codes and Dates</b> Required when there is a condition code that applies to this claim. Form locators 31, 32, 33, and 34 – allow both an occurrence codes and a date. Dates must be in MMDDYY format. The Occurrence Span Code can contain an occurrence code where the “Through” date would not contain an entry.</p> <p><b>Valid Occurrence Codes</b></p> <p><b>Accident Related Codes</b> 01 = Accident/Medical Coverage 02 = No-Fault Insurance Involved 03 = Accident/Tort Liability 04 = Accident/Employment Related 05 = Accident/No Medical or Liability Coverage 06 = Crime Victim</p> <p><b>Medical Condition Codes</b> 09 = Start of Infertility Treatment Cycle 10 = Last Menstrual Period 11 = Onset of Symptoms/Illness (Outpatient claims only.) 12 = Date of Onset for a Chronically Dependent Individual (CDI) (HHA Claims Only)</p> <p><b>Insurance Related Codes</b> 16 = Date of Last Therapy 17 = Date Outpatient Occupational Therapy Plan Established or Reviewed 18 = Date of Retirement Patient/Beneficiary. 19 = Date of Retirement Spouse 20 = Guarantee of Payment Began (Part A hospital claims only) 21 = UR Notice Received (Part A SNF claims only.) 22 = Date Active Care Ended 23 = Date of Cancellation of Hospice Election Period 24 = Date Insurance Denied 25 = Date Benefits Terminated by Primary Payer 26 = Date SNF Bed Available 27 = Date of Hospice Certification or Re-Certification 28 = Date CORF Plan Established or Last 29 = Date OPT Plan Established or Last Reviewed 30 = Date Outpatient Speech Pathology Plan Established or Last Reviewed 31 = Date Beneficiary Notified of Intent to Bill (Accommodations) 32 = Date Beneficiary Notified of Intent to Bill (Procedures or</p>

Requirements	Form Locator	Description
		<p>Treatments)</p> <p>33 = First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP</p> <p>34 = Date of Election of Extended Care Services</p> <p>35 = Date Treatment Started for Physical Therapy</p> <p>36 = Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s)</p> <p>37 = Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant</p> <p>38 = Date treatment started for Home IV Therapy</p> <p>39 = Date discharged on a continuous course of IV</p> <p>40 = Scheduled Date of Admission</p> <p>41 = Date of First Test for Pre-admission Testing</p> <p>42 = Date of Discharge (Hospice claims only)</p> <p>43 = Scheduled Date of Cancelled Surgery</p> <p>45 = Date Treatment Started for Speech Therapy</p> <p>46 = Date Treatment Started for Cardiac</p> <p>47 = Date Cost Outlier Status Begins</p> <p><b>Service Related Codes</b></p> <p>A1 = Birth Date-Insured A The birth-date of the insured in whose name the insurance is carried.</p> <p>A2 = Effective Date-Insured A Policy</p> <p>A3 = Benefits Exhausted</p> <p>A4 = Split Bill Date</p> <p>B1 = Birth Date-Insured B</p> <p>B2 = Effective Date-Insured B Policy</p> <p>B3 = Benefits Exhausted</p> <p>C1 = Birth Date-Insured C</p> <p>C2 = Effective Date-Insured C Policy</p> <p>C3 = Benefits Exhausted</p> <p>70 = Qualifying Stay Dates (Part A claims for SNF level of care only)</p> <p>71 = Hospital Prior Stay Dates (Part A claims only)</p> <p>72 = First/Last Visit</p> <p>74 = Non-covered Level of Care</p> <p><b>Codes 76 and 77 apply to most non-covered care</b></p> <p>76 = Patient Liability The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary.</p> <p>77 = Provider Liability- Utilization Charged The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care)</p> <p>M2 = Dates of Inpatient Respite From/Through dates of a period of inpatient</p> <p>M3 = ICF Level of Care</p> <p>M4 = Residential Level of Care</p>

Requirements	Form Locator	Description
	37:	Untitled Not used.
	38:	<b>Responsible Party Name and Address</b>
Required	39 – 41 a - d:	<p><b>Value Codes and Amounts</b> Enter value code. Amount is required when a value code is entered. If value code 45 is entered then amount needs to reflect an admission hour (see Form Locator 13).</p> <p><b>Valid Value Codes</b>  01 = Most common semi-private rate  02 = Hospital has no semi-private rooms  03 = Inpatient professional component charges which are combined billed  04 = Inpatient professional component charges which are combined billed  05 = Professional component included in charges and also billed separate to carrier  06 = Medicare blood deductible  08 = Medicare life time reserve amount in the first calendar year  09 = Medicare coinsurance amount in the first calendar year  10 = Lifetime reserve amount in the second calendar year  11 = Coinsurance amount in the second calendar year  12 = Working aged beneficiary/spouse with employer group health plan.  13 = ESRD beneficiary in a Medicare coordination period with an employer group health plan  14 = No fault, including auto/other  15 = Worker's compensation  16 = PHS or other federal agency</p> <p><b>Medicaid Specific Codes</b>  21 = Catastrophic  22 = Surplus  23 = Recurring monthly income  24 = Medicaid rate code</p> <p><b>Reserved Codes</b>  31 = Patient liability amount  32 = Multiple Patient Ambulance Transport  37 = Pints of blood furnished  38 = Blood deductible pints  39 = Pints of blood replaced  40 = New coverage not implemented by HMO (for inpatient service only)  41 = Black Lung  42 = VA  43 = Disabled beneficiary under age 65 with LGHP  44 = Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received, then a Medicare secondary payment is due  45 = Accident Hour  46 = Number of grace days  47 = Any liability insurance  48 = Hemoglobin reading</p>

Requirements	Form Locator	Description
		<p>49 = Hematocrit reading  50 = Number of physical therapy visits from onset (at the billing provider through this billing period)  51 = Number of occupational therapy visits from onset of symptoms ( at the billing provider through this billing period)  52 = Number of speech therapy visits from onset of symptoms (at the billing provider)  53 = Number of cardiac rehabilitation visits (at the billing provider through this billing period)  54 = Newborn birth weight in grams</p> <p><b>Home Health Specific Codes</b>  56 = Skilled nursing - home visit hours (HHA only)  57 = Home health aide - home visit hours (HHA only)  58 = Arterial blood gas value  59 = Oxygen saturation value  60 = HHA branch MSA  61 = Place of residence where service is furnished (HHA and Hospice)  67 = Peritoneal dialysis  68 = Number of units of EPO drug administered and/or supplied  71 = Funding of ESRD Networks  72 = Flat Rate Surgery Charge  73 = Drug deductible  74 = Drug coinsurance  76 = Provider's Interim Rate  80 = Covered days  81 = Non-covered days  82 = Co-insurance days  83 = Lifetime Reserve days</p> <p><b>Deductible Coinsurance Codes</b>  A1 = Deductible amount Payer A  B1 = Deductible amount Payer B  C1 = Deductible amount Payer C  A2 = Coinsurance amount Payer A  B2 = Coinsurance amount Payer B  C2 = Coinsurance amount Payer C  A3 = Estimated responsibility Payer A  B3 = Estimated responsibility Payer B  C3 = Estimated responsibility Payer C  D3 = Estimated responsibility patient  A4 = Covered self-administrable drugs – emergency  A5 = Covered self-administrable drugs – not self-administrable in form and situation furnished to patient  A6 = Covered Self-Administrable Drugs – Diagnostic Study and Other (For use with Revenue Code 0637)  A7 = Co-payment Payer A  B7 = Copayment Payer B  C7 = Copayment Payer C  A8 = Patient Weight  A9 = Patient Height  G8 = Facility where inpatient hospice service is delivered</p>
<b>Required for each charge entered</b>	<b>42:</b>	<p><b>Revenue Code</b>  An accommodation revenue code (0100-0219) is required for all</p>

Requirements	Form Locator	Description
		inpatient type of bill (TOB).
Optional	43:	<b>Revenue Description</b> A narrative description of the related revenue categories included on the claim. Abbreviations may be used.
Recommended	43:	<b>Revenue Description for National Drug Code (NDC) information</b> Enter the two-digit Product ID Qualifier "N4" in the first two positions, immediately followed by the NDC code with no hyphens. Directly following the last digit of the NDC (no delimiter), enter the two-digit Unit of Measurement Qualifier. Immediately following the Unit of Measurement Qualifier, enter the nine-digit quantity. The nine digits consist of six digits for the whole number, followed by the three-digit decimal portion of the number.  <b>Valid Unit of Measurement Qualifiers are:</b> F2 – International unit GR – Gram ML – Milliliter UN – Unit  The HCPCS code should be entered in Form Locator 44 and the Units in Form Locator 46.
Required	44:	<b>HCPCS/Rates/HIPPS Rate Codes</b> A CPT or HCPCS code is required for outpatient services or supplies.
Required	45:	<b>Service Date</b> Enter the date that the services were provided. Must be in MMDDCCYY format.
Required	46:	<b>Units of Service</b> Enter the number of units rendered for each service. Units can be hours, days/sessions, tests/services or items
Required for each revenue code entered	47:	<b>Total Charges</b> Enter total charges Enter total charges pertaining to the related revenue code for the current billing period. Zeros are valid.
Optional	48:	<b>Non-Covered Charges</b> Enter non-covered charges.
	49:	<b>Untitled</b> Not used.
	51 a- c:	<b>Health Plan ID</b> See Form locators 56 and 57 for NPI and Regence Identifier fields.
Required	52 a – c:	<b>Release of Information Certification Indicator</b> A "Y" code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate

Requirements	Form Locator	Description
		the claim. This is required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An "I" code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.
Optional	53 a – c:	Assignment of Benefits Certification Indicator
Optional	54 a – c:	Prior Payments-Payers and Patient Enter the amount of the prior payments from other insurance.
Optional	55 a – c:	Estimated Amount Due from patient
<b>Required for electronic claim submissions</b>	<b>56:</b>	<b>Billing Provider National Provider ID (NPI)</b> Effective March 1, 2008, the billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
<b>Required for paper claim submissions if NPI is not submitted in form locator 56</b>	<b>57:</b>	<b>Other Provider ID (primary, secondary, and/or tertiary)</b> Use this field to report your Regence provider identification number if submitting a paper claim without an NPI.  Until further notice, a billing provider can electronically submit both an NPI and a Regence provider identification number.
<b>Required</b>	<b>58</b> a – c:	<b>Insured's Name</b> Enter the insured's last name, first name and middle initial as it appears on the identification card.
<b>Required</b>	<b>59</b> a – c:	<b>Patient's Relationship to Insured</b> Enter patient's relationship to insured code.  01 = Spouse 18 = Self 19 = Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other Relationship
<b>Required</b>	<b>60</b> a – c:	<b>Insured's Unique Identification (ID)</b> Enter insured's identification number as shown on member card.
Optional	61 a – c:	Insured's Group Name
<b>Required</b>	<b>62</b> a – c:	<b>Insurance Group Number</b> Enter the insured's group number as shown on the member card.  <b>Exception:</b> If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)

Requirements	Form Locator	Description
Optional	63:	Treatment Authorization Code
Optional	64:	Document Control Number (DCN)
Optional	65:	Employer Name
Optional	66:	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) The qualifier denotes the version of <i>International Classification of Diseases</i> (ICD) reported. The following qualifier code reflects the edition portion of the ICD: 9 – Ninth Revision
Required	67:	<b>Principal Diagnosis Code and Present on Admission Indicator</b> Enter the ICD-9 diagnosis code for the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for this hospital admission. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. Do not include the decimal between the third and fourth digits. "V" codes are acceptable as principal diagnoses.  This field is eight positions long. The principal diagnosis is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.
Required	67A – 67Q:	<b>Other Diagnoses Codes</b> Enter up to seventeen ICD-9 diagnosis codes for the other diagnoses. The codes must be the full ICD-9 diagnosis codes, including all five digits where applicable. Do not include the decimal between the third and fourth digits. Both "V" and "E" codes may be entered as other diagnoses, though E codes are preferably billed in form locator 72.  There are 17 Other Diagnosis fields. Each Other Diagnosis field is eight positions long. The diagnosis code is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.  Diagnosis codes must be carried to their highest degree of detail. Do not duplicate the principal diagnosis in this field.
	68:	Untitled Not used.
Required for inpatient type of bills	69:	<b>Admitting Diagnosis</b> Must be a valid ICD diagnosis code. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.
Required for outpatient if applicable	70 a – c:	<b>Patient's Reason for Visit</b> Required for all unscheduled outpatient visits for outpatient bills.
Optional	71:	Prospective Payment System (PPS) Code
Required if applicable	72:	<b>External Cause of Injury Code (E-Code)</b>

Requirements	Form Locator	Description
		<p>Enter up to three E-Codes if an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. The codes must be the full ICD-9 E-code, including all five digits where applicable. Do not include the decimal between the fourth and fifth positions.</p> <p>There are 3 E-Code fields. Each E-Code field is eight positions long. The E-Code is entered in positions 1 - 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.</p>
	73:	Untitled Not used.
<b>Required for inpatient type of bills if applicable</b>	<b>74:</b>	<b>Principal Procedure Code and Date</b> Enter the principal procedure code and date. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
<b>Required for inpatient type of bills if applicable</b>	<b>74A – 74E:</b>	<b>Other Procedure Codes and Dates</b> Enter up to five other procedure codes and dates. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
	75:	Untitled Not used.
<b>Required</b>	<b>76:</b>	<b>Attending Provider Name and Identifiers (including NPI)</b> Enter the unique provider's NPI and the name of the attending physician for inpatient bills or the physician that requested the outpatient services.  Definition of attending provider: The provider who is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter.
Optional	77:	Operating Provider Name and Identifiers (including NPI)
Optional	78 and 79:	Other Provider Name and Identifiers (including NPI)

Requirements	Form Locator	Description
<b><i>Required under the circumstances listed</i></b>	<b>80:</b>	<b>Remarks</b> <ol style="list-style-type: none"> <li>1. Enter accident information if occurrence codes 01-05 are entered and/or diagnosis codes 800-959.9, E800-849, E880-E929, E969-E999 are entered.</li> <li>2. Specify the type of drug, implant, or device if a HCPCS code cannot identify them.</li> <li>3. Specify if ionic or non-ionic contrast media was used for revenue codes 255, 350, 351, 352, or 359.</li> <li>4. Enter information relating to emergency room visit if revenue code 450 or 459 is used.</li> <li>5. Enter description of service, training schedule or name of educational program if revenue code 942 is used.</li> <li>6. Facilities with programs for partial day and intensive outpatient programs should indicate "full" partial, "half" partial, or intensive outpatient program. This additional information will help determine the correct benefits when processing the claim.</li> </ol>
<b>Recommended</b>	<b>81:</b>	<b>Code-Code Field</b> Enter for the following: A1 = NUBC Condition Codes (FL 18-28) A2 = NUBC Occurrence Codes/Dates A3 = NUBC Occurrence Span A4 = NUBC Value Codes (FL 39-41)

# Sample UB-04 claim form

1		2		3a PRI. CNTRL. #		4 TYPE OF BILL	
				3b INCL. REC. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PRESENT NAME		9 PRESENT ADDRESS					
b		c		d		e	
10 BIRTHDATE	11 SEX	12 DATE	13 ADMISSION	14 TYPE	15 SEC	16 ICD-9	17 ICD-9
						18	19
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## Submitting Supporting Documentation

When we request your office to submit supporting documentation, it is typically indicated by the message code on your voucher. Please use the “*Supporting Documentation Coversheet*” form found on our *Provider Web Site* in the Provider Library section, under Forms to submit documentation for electronic or paper claims. This form was developed to facilitate the process of sending and matching hard copy documentation required on certain electronic or paper claims.

## Where to find information regarding medical and reimbursement policy

Reimbursement and medical policy can be found on the *Provider Web Site* in the Provider Library section, under Policies. We make every effort to notify you if we make a change to billing guidelines or administrative, medical or reimbursement policies. In most cases notification will be via *The Connection Online*<sup>SM</sup> newsletter.

## Resubmitting Claims

Claims are generally processed within 14 days after receipt. Participating physicians, health care professionals, and facilities have agreed to refrain from submitting duplicate claims.

## Corrected billing

We consider a **corrected billing** to be any claim that has a correction to an original claim. This could be a procedure code, diagnosis, date of service, member name, member date of birth, etc. For example, the physician may have omitted a procedure by mistake and would like to correct that bill by submitting the additional procedure. We have a *Corrected Claim Coversheet* form to help facilitate corrected billings. You **do not** need to submit supporting documentation for a corrected claim to us for processing. Below are the steps to follow to submit a corrected billing:

- Use the *Corrected Claim Coversheet* form found on our *Provider Web Site* on the Provider Library section, under Forms. Submit corrected billings on paper to the correspondence address listed above
- Attach the *Corrected Claim Coversheet* form, indicating the change (diagnosis, procedure code, etc.)
- Do not submit supporting documentation for the change/correction

## Rebilling

Regence considers a **rebilling** to be the same as a new claim. They are claims that have never made it into our system.

- If you file paper claims and have not received a payment voucher or remittance advice after 30 days, please check the Provider Center to determine whether your claim was received.
- If you file claims electronically, regularly check your error reports to ensure the claim was received by Regence, and that it hasn't been blocked due to an information error. The following transaction codes may be helpful in determining if your claim was received, rejected, or in process:
  - Transaction 997 acknowledges only that the entire batch was received or rejected. It does not verify that valid data was entered on an every claim. If one claim is rejected on the 997 report, the entire batch will be rejected.
  - Transaction 864 notifies you of data errors on individual claims.
  - Transaction 277FE verifies that a claim is eligible for payment
  - Transaction 276 enables you to send a claim status inquiry and
  - Transaction 277 is the response to that claim status inquiry

If your claim is not on file and in process after 30 days, you may resubmit the claim as follows:

- You may submit rebills electronically; or, if paper, submit claims to the claims address listed above.
- Do not submit supporting documentation
- Do not mark the claim 'rebill'
- Submit as you would a regular claim

## Prompt Pay

Regence BlueCross BlueShield of Utah (Regence BCBSU) makes every effort to pay or deny clean claims within thirty (30) days of receipt. A clean claim is a claim submitted on a properly completed *CMS-1500* or *UB-04* claim form, or other mutually acceptable claim form. Regence BCBSU determines what claims do not require substantiating documentation from the provider, information from a third party, or further review to determine our liability for payment.

Please refer to the Utah participating agreement for more specific information regarding timely payment.

## Process to Request an Adjustment

Please see your participating agreement for information regarding refunds and adjustments.

## Refunds

Regence requires that any payment determined to be in error will be promptly refunded to the Company. Regence has the right to deduct any incorrectly paid amounts from future payments to you but is not limited to this remedy. Please immediately notify us of any payment that was made in error.

## Refund and/or credit requests

Credit and refund adjustments for participating providers are automatically processed by our system. These transactions are reflected on your voucher. If a refund is requested, the monies must be received by Regence within 30 days of the date of the refund letter. Otherwise, a credit of the applicable amount will be posted against the provider's account and the money will be deducted from future payments(s) to the provider. Always return a copy of the applicable voucher, along with a note of explanation with any refunds you remit. A convenient form is available in the Provider Library section of our *Provider Web Site*. Click on the *Refund Notification* link under Claims and billing forms.

Please submit refund payments to:

Utah Claims Recovery  
P.O. Box 91067  
Seattle, WA 98111-9167

If you prefer a credit to be taken immediately, please contact Provider Customer Service.

## Time limits for adjustments, deductions and/or refunds

Occasionally a payment error may require Regence to make an adjustment or deduction from a provider's payment voucher or may require a provider to refund money to Regence. These cases may be discovered by Regence during routine audits or may be brought to light by a provider or subscriber.

The following time limitations apply:

Effective May 12 -

- Adjustments due to a recovery by Medicare, Medicaid, Children's Health Insurance Pool (CHIP) or any other federal health care program are limited to 36 months.
- Adjustments due to any other reason (other than COB as noted below) are limited to 12 months.

Effective July 1 -

- Adjustments due to a recovery related to Coordination of Benefits (COB) are limited to 24 months.

These time limitations, as established by Utah House Bill 165, apply to all Utah insurers as well as physicians, other health care professionals and facilities.

Exception to the policy above:

- In the case of fraud or other intentional misconduct, the period for requesting an adjustment or disputing a claim is the maximum time allowed by law.

# Coordinating Multiple Coverage

Most health plans contain provisions for coordinating benefits when a member is covered under two or more plans. The most common of these provisions are coordination of benefits (COB) and maintenance of benefits (MOB).

## Coordination of Benefits

Coordination of Benefits (COB) ensures that the total amount paid by all health plans does not equal more than the actual cost of treatment. Coordination of benefits is vital in keeping the cost of coverage as low as possible.

## Maintenance of Benefits

Maintenance of Benefits (MOB) allows your patients to receive benefits from all health insurance plans under which they have coverage while maintaining patient responsibility for coinsurance and/or copay amounts on these plans. It also ensures the total combined payment from all sources never exceeds the total charges.

With MOB processing, secondary payers only allow benefits up to their own maximum allowable for the specific service(s). If the primary carrier's payment is equal to or more than what the secondary carrier's payment would have been as primary, no additional benefits will be remitted. This can result in members having out-of-pocket expenses, something not usually seen with COB processing.

## Submitting claims

If your patient is covered by two group benefit contracts through Regence, be sure to list both of the employers group and employer identification numbers on the claim. It is not necessary to send in two separate claims.

Workers' Compensation statutes provide that Workers' Compensation insurance is **primary coverage** for all job-related injury or illness claims. These claims should be sent to the patient's Workers' Compensation carrier, not to Regence.

## Secondary submission

- If you are submitting a paper claim, please attach the Explanation of Benefits or the voucher from the primary insurance for proper coordination.
- If you are submitting an electronic claim, be sure to complete all the other insurance payment fields correctly to ensure proper coordination with the primary payer. Please follow your guidelines for electronic submissions. If you have any questions regarding the electronic format, please contact your provider consultant.

## Order of payment

Health plans use standard industry guidelines to determine the “primary” plan, that is, the one that pays first. When Regence is the primary coverage, we provide reimbursement according to the member’s contract terms, up to our allowable fee.

Regence uses the following guidelines to determine primacy when more than one health plan is involved.

***Birthday rule:*** *The birthday rule is a guide for coordination of benefits. The coverage belonging to the parent, whose birthday (month and day only) comes first in the year, will be the primary coverage. Do not take into account the year of birth. If the parents have the same birth date (month and day), the coverage of the parent who has had his or her coverage longest, will be primary. This applies whether or not the dependents have been covered from the original effective date or added recently to either coverage.*

***Natural parent, living together, never married:*** The ‘birthday’ rule applies. When a relationship dissolves, often dependent children are usually covered for health insurance by only one parent, or are court ordered to be covered in some other way. Occasionally there are no legal agreements that itemize how a dependent should be covered.

***Divorced parents:*** *Regence will obtain a copy of the divorce decree and follow the arrangements made in the maintenance agreement. If no agreement has been mandated, the custodial parent will be primary.*

***One parent has financial responsibility and the other parent has custody:*** Primacy is based on who has custody. See below, listed in the order of coordination:

1. Natural parent with custody
2. Spouse of parent with custody
3. Other natural parent
4. Spouse of the other natural parent

***One parent has both custody and full financial responsibility:***

1. Natural parent with financial responsibility
2. Other natural parent
3. Spouse of parent with custody
4. Spouse of other natural parent

***Dependent resides with each parent 50% of the time (joint custody):***

1. Natural parent with financial responsibility and custody
2. Spouse of parent with financial responsibility and custody
3. Other natural parent
4. Spouse of other natural parent

***Dependent resides with one parent MORE than 50% of the time:***

1. Natural parent whose insurance plan covered dependent the longest period of time
2. Other natural parent
3. Spouse of parent whose insurance plan covered dependent the longest period of time
4. Spouse of the other natural parent

**Natural father has financial responsibility and natural mother has custody, but NEITHER parent has health coverage for the dependent:**

1. Stepfather (spouse of parent with custody)
2. Stepmother (spouse of other natural parent)

**Natural father has financial responsibility until the child is 18 and the natural mother has custody, and the child is now 18:**

1. Natural parent whose insurance plan covered dependent for longest period of time
2. Other natural parent
3. Spouse of parent whose insurance plan covered dependent for longest period of time

## Payment Allowance

In no event will Regence's payment for covered services together with the payment made by the primary carrier exceed the amount that would have been payable if Regence had been the primary carrier.

The participating provider agrees to accept the negotiated amount as payment in full, whether that amount is paid in whole or part by the member, by Regence, or by any combination of payers, including other payers that may pay as primary.

<p><b>Note:</b> As stipulated in your Agreement, any balance remaining cannot be billed to the member.</p>
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## Medicare Crossover claims

If you accept Medicare assignment and render services to members, please note the following.

**Medicare is primary:** When Medicare is the primary payer, follow these procedures:

- 1) Submit claims to your local Medicare contractor first. **Do not file with Medicare and the supplemental insurer simultaneously.** Be sure to include the:
  - Complete Health Insurance Claim Number (HICN),
  - The patient's complete member number,
  - Patient's name as it appears on the card and
  - Other carrier's name and address (OCNA) number. If you include this information, make sure it is the correct OCNA for the member's Blue Plan.
- 2) After you receive the *Explanation of Medical Benefits* (EOMB) or payment advice from Medicare, determine if the claim was automatically crossed over to the supplemental insurer:
  - **Crossed over:** If the indicator on the EOMB or payment advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to Regence BCBSU or the appropriate Blue Plan and the claim is in process. You do not need to file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you, if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

The Centers for Medicare & Medicaid Services (CMS) requires providers to obtain a Coordination of Benefits Agreement (COBA) identification number to add to crossover claims. Regence BCBSU already shares its eligibility files with Medicare and receives secondary crossover claims directly from Medicare. Therefore, it is not necessary for you to include a COBA number on these claims.

- **Not crossed over:** If the indicator on the EOMB or payment advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim as you do today to Regence BCBSU along with the payment advice. Regence BCBSU or the member's Blue Plan will pay you the Medicare supplemental benefits. If you did not accept Medicare assignment, the member will be paid and you will need to bill the member.

**Regence BCBSU is primary:** When Regence or another Blue Plan is the primary payer (e.g., Medicare Advantage), submit claims to Regence BCBSU. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Based on CMS regulations, if you are a physician, other health care professional or facility who accepts Medicare assignment and renders service to Medicare Advantage members, you will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than your charge amount. CMS regulations state that the Medicare allowable amount is considered payment in full.

*Note:* Medicare Advantage Private Fee for Service (PFFS) reimbursement is paid at the Home plan contracted rate or Medicare rate, depending on the member contract.

Other than the applicable member cost sharing amounts, reimbursement is made directly by Regence BCBSU. You may collect only the applicable cost sharing (i.e., copayment), amounts from the member at the time of service, and may not otherwise charge or balance bill.

## Other Party Liability and Subrogation

### Other party liability

When a person is injured in an accident, the member's health plan may not be financially responsible for covering the cost of the required care. This is called Other Party Liability (OPL), i.e., when financial responsibility for coverage shifts from a member's health plan to a third party. For example, if a person is injured in a car accident, the automobile insurance company may be financially responsible. If a person is injured at work, Labor and Industries (L & I) may be financially responsible.

When a member receives care for injuries or medical conditions sustained during an accident, health plans need information about the injury in order to determine who is financially responsible, i.e., L & I, an automobile insurer, some other third party, etc.

If a member is involved in an accident, bill in the usual manner, adding the place, exact date, time and cause of injury. All injury claims are investigated for the cause of the injury. To save time and expedite claims processing, please indicate the cause of the injury and the date of the injury on the original submission of the claim.

If no injury is present, use an illness diagnosis code 001-799. If the member has a condition such as “back pain” with no specific date of injury, use an illness code instead of an injury code. Make sure to state on the claim that it is not an injury.

On all possible third-party accident claims, the member will be sent an ‘Incident Report’ form. When this form is completed by the member or returned, claims will be processed in one of the following ways:

- If benefits are payable under the terms of any automobile medical, automobile no-fault, homeowners, premises liability, personal injury protection or similar contract of insurance **or**,
- If the subscriber/ member fails to provide complete information upon request, claims are denied accordingly.

When we are notified in writing that the above mentioned benefits do not exist, have expired, or have been exhausted, Regence will then begin processing claims and resume the pursue process in attempt to recover payments made on behalf of the subscriber/member.

If the member does not submit their incident/injury report, the health plan may deny the providers claim. In this situation, the provider can bill the member directly to collect fees for services provided.

The ‘Incident Report’ form is located on our *Provider Web Site* in the Provider Library section under Forms.

**Note:** Please do not submit an incident report unless one is requested by Regence.

### Other party liability threshold

When coverage responsibility is unclear, health plans may pay the claim if the total charge is below the threshold level. This is called the “Other Party Liability” (OPL) threshold. Regence has a \$500 threshold for most injury claims. Once a claim that totals the OPL threshold amount is received the OPL investigation will begin. When an investigation is started, all related claims regardless of the dollar amount will be subject to the OPL investigation.

The following table will list the diagnoses Regence considers investigative for injuries and the dollar threshold associated:

Diagnosis	OPL Threshold (if not less than \$500)	Diagnosis	OPL Threshold (if not less than \$500)
008-008.8	\$1000	900 – 999.9	\$500
310.2	\$1000	E800 – 819.9	\$500
310.4	\$1000	E822 – 869.9	\$500
353 – 353.5	\$500	E880 – 888	\$500
353.6 – 353.9	\$500	E894 – 899	\$500
354 – 354.9	\$0	E901.1 - 902.1	\$500
550 – 550.93	\$0	E906 – 906.0	\$500
717 – 717.9	\$500	E910.3	\$500
718 – 718.99	\$500	E914 – 915	\$500
719 – 719.99	\$500	E918 – 919.9	\$500
721 – 721.91	\$1000	E921 – 921.9	\$500
722 – 722.93	\$1000	E923 – 923.9	\$500
723 – 723.9	\$1000	E929 – 929.9	\$500
724 – 724.9	\$1000	All other ‘E’ codes	\$500
800 – 898.82	\$500		

- If one of the above diagnoses is used and the visit is NOT accident related, please use the following abbreviations in the comment or remarks section of the claim:  
‘ACC-NKI’ or ‘ACC- No Known Injury’
- If any ‘E’ code is used, accident description and information is still required.
- If the threshold equals ‘\$0’, ALL claims for the injury will be investigated.

**Utah guidelines for no-fault auto accidents:** *The No-fault law in effect in Utah states that anyone residing in the state of Utah for more than 90 days is to have his/her car licensed in Utah and must carry the minimum No-fault coverage of \$3,000 (additional coverage up to \$100,000 can be purchased). This law applies to every vehicle including dump trucks, school buses, commuter buses, etc. Any vehicle that is used specifically for intrastate purposes is subject to the No-fault law. Any vehicle licensed in Utah, except 18-wheelers used for interstate travel must carry No-fault coverage.*

**Utah guidelines for no-fault coverage:** Utah law states that any claim for injury occurring in, on or around a vehicle is to be filed with the auto carrier and paid out of the No-fault benefit.

The following are some examples of claims that should be filed with the auto carrier:

- Auto/bike or auto/tricycle accidents; this applies whether the vehicle is moving or parked
- Riding a skateboard or inline skating and colliding with an auto
- Auto/pedestrian accidents
- Hit and run accidents must be filed with the family of the injured persons’ No-fault coverage before the health insurance carrier pays
- Baby falls out of a car seat or car window
- Changing a tire or repairing the car and an injury occurs
- Smashed finger in car door
- Trailers attached to a vehicle are considered an integral part of the vehicle and subject to No-fault unless they are parked and being used as a residence

It is the member’s responsibility to provide us with the (personal injury protection) PIP log from his/her automobile insurer. It is our policy to send a letter to the member asking for this information. As soon as the PIP log is received, all claims that were not paid by No-fault are processed according to contract benefits.

**Other party liability for BlueCard members**

In cases where a BlueCard member is involved, submit OPL information with the claim to Regence BCBSU. Upon receipt, Regence BCBSU will electronically route the claim to the member’s Blue Plan. The member’s Blue Plan will then process the claim and approve any payment based on the member’s benefits. Regence BCBSU will reimburse you accordingly and provide information on your payment voucher.

**Workers Compensation**

Any accident that occurs at the workplace, whether during regular hours or after, or at another place while on work business, is considered industrial and should be filed with the industrial carrier. Medical problems that occur as a result of employment are also industrial.

Examples of industrial cases are as follows:

- Cut finger on file cabinet.
- Fall down stairs or in parking lot.
- Cellulitis resulting from a cut or burn at work.
- Lung ailments caused by breathing caustic fumes or gases.
- Carpal tunnel or other such repetitive motion injuries.
- Auto accident while delivering packages to the post office or on a delivery route or while on the way to a business meeting.
- Heart, back, hernia, knee or psychiatric problems directly related to employment.

## **Subrogation**

Subrogation is defined as the right to recover payments. There has to be Other Party Liability in order to recover payments. Subrogation occurs when someone is injured on another person's property or as the result of another person's negligence.

Example of subrogation situations are as follows:

- Fall in a store or parking lot
- Neighbor's dog or cat bites you
- Altercations
- Assaults
- Motorcycle accidents
- Off road vehicle accidents
- Boating accidents
- Any injury that is caused through the fault or negligence of someone else
- Automobile accidents after No-fault is met
- Workers Compensation accidents when denied and being appealed

## **Use of "unlisted procedure" codes**

Unlisted procedure codes require manual processing and pricing. This process requires submission of documentation to support the use of such codes. The most common uses of unlisted codes are described below.

### **Incorrect usage**

Submitting an unlisted code on the claim when the procedure described in the operative report has a more specific CPT code available. These codes will be paid at the reimbursement rate of the more specific valid CPT code.

Submitting an unlisted code on the claim in addition to other specific codes, with no evidence in the operative report of separate services being rendered. Often times on these claims it is unclear what service is being linked to the code. Other times the service is considered unbundled from the primary codes. No additional reimbursement is warranted in these cases.

## Correct usage

1. An unlisted code is submitted correctly to identify a procedure that does not currently have an adequate CPT code description. Common examples of these services are:
  - The procedure is performed by endoscopy or by laparoscopy. These procedures will usually be reimbursed at the rate of the equivalent open procedure.
  - The procedure is performed using a device other than what is described in an existing CPT code. These procedures will usually be reimbursed at the rate of the existing described procedure.
  - The procedure performed is directed toward a specific anatomical location, but the intent of the procedure is somewhat different than an existing code. These will usually be reimbursed at the rate of the existing described procedure. Consideration will be given for additional payment if added complexity is evident.
  - The procedure performed is unique. These procedures will be reimbursed per terms of the provider contract. If such procedures are seen repeatedly (i.e. emerging technology) a price will be established by Regence based on an assessment of work requirements compared to existing procedure descriptions and their respective Relative Value Units (RVUs).

New procedure codes are added to coding books every year. Please refer to the most current CPT code book prior to submitting an unlisted procedure code to verify there is not a more appropriate code available.