Blue Choice PPO^{SM} and
Blue High Performance Network^{SM} (BlueHPN)^{SM}
Provider Manual – Filing Claims - Electronic Filing

Important note:

Throughout this provider manual there will be instances when there are references unique to Blue Choice PPO, Blue High Performance Network, Blue Edge, EPO and the Federal Employee Program 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 PPO products.

In this Section

The following topics are covered in this section:

Blue Choice PPO and Blue High Performance (BlueHPN) Provider Manual – Filing Claims - Electronic Filing

Electronic Claim 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. Blue Cross and Blue Shield of Texas (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 stockholders through a secure internet-based exchange. The Availity Health Information Network encompasses administrative and clinical services, supports both real-time and batch transactions via the Web and electronic data interchange (EDI) and is HIPAA compliant. Availity is the recipient of several national and regional awards, including Consumer-Directed Health Care, A.S.A.P. Alliance Innovation, eHealthcare Leadership, Northeast Florida Excellence in IT Leadership, E-Fusion, Emerging Technologies, and Healthcare Innovations Excellence (TERHIE), and AstraZeneca-NMHCC Partnership. For more information, including an online demonstration, visit www.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 daily and include all claims *(whether submitted on paper or submitted electronically)*. This process allows you to automatically post payments to your patient's 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 electronic remittance advice in the following format and version:

- **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 835 ERA Standard Companion Guide🗎 . For further assistance, email Electronic Commerce Services or refer to Electronic Commerce on the provider website.

Blue Choice PPO and Blue High Performance (BlueHPN) Provider Manual – Filing Claims - Electronic Filing

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. Reimbursement by EFT is 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 835 EFT Standard Companion 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 at the same time as your ERA. The paper PCS is discontinued 31 days after the provider is enrolled for ERA's.

Electronic Claim Submission and Payer Response Reports

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

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

Blue Choice PPO
and Blue High Performance Network (BlueHPN)
Provider Manual – Filing Claims - Electronic Filing

Payer Response Reports

BCBSTX supplies Payer Response Reports to our 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 Blue Cross, Blue Shield, Federal Employee Program® (FEP®), and BlueCard.

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 607445D26102X. The first four digits of the DCN indicate the date: 6(year=2016), 074 (Julian date = March 15). The final digit of 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. The claim will either be processed or you will receive a letter notifying you the claim must be resubmitted.

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

System Implications

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, we recommend that your software have the capability to electronically retransmit individually rejected claims.

BlueCross BlueShield of Texas

Blue Choice PPO
and Blue High Performance Network (BlueHPN)
Provider Manual – Filing Claims - Electronic Filing

Benefits of Electronic Medical Claims (EMC)/ Electronic Data Interchange (EDI)

- Turnaround time is faster for BCBSTX 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.

- You have more control of claims filed electronically. The data you submit electronically is imported info our claims processing system - there is no need for intermediate data entry.

- Up-front claims editing helps reduce returned claims.

- Make sure all corrected claims are refiled electronically.

- You can transmit claims - 24 hours a day, seven days a week.

- For support relating to electronic claims submission and/or other transactions available with Availity, contact Availity Client Services at **1-800-AVAILITY** (282-4548).

- The patient's account number appears on every EPS or PCS that you receive, which expedites posting of payment information.

Payer Identification Code

Blue Choice PPO health care providers submitting claims via the Availity 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.

BlueCross BlueShield of Texas

Blue Choice PPO
and Blue High Performance Network (Blue HPN)
Provider Manual – Filing Claims - Electronic Filing

What BCBSTX PPO Claims Can be Filed Electronically?	All BCBSTX claims including: • Out-of-state • Federal Employee Program (FEP) • Blue Choice PPO • Blue High Performance (Blue HPN) • Blue Cross and Blue Shield secondary claims • Corrected and replacement claims • All claim types may be filed electronically
Availity Authorization & Referral Confirmation Number	If the services require a prior authorization by BCBSTX Utilization Management, these requests can be submitted online via Availity's Authorizations & Referrals tool or by calling the Utilization Management Department. The Availity Authorizations & Referrals' confirmation number or the Utilization Management Department's authorization 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.
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 **800-AVAILITY (282-4548)** or by visiting the Availty 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	BCBSTX secondary claims can be submitted electronically. To do so requires NO explanation of benefits; however, prior payer information must be included in the appropriate loops and segments of the electronic claims submitted to BCBSTX. All BCBSTX rules for referral notification and prior authorization/precertification requirements must be followed.

Blue Choice PPO and Blue High Performance Network (Blue HPN) Provider Manual – Filing Claims - Electronic Filing

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 (PPO)^{SM} Supplement .
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.*

By clicking this link, you will go to a new website/app ("site"). This new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. In addition, some sites may require you to agree to their terms of use and privacy policy.

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. Other Adobe accessibility tools and information can be downloaded at http://access.adobe.com .