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Appendix for Section 4

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Reimbursement for Outpatient Services

Reimbursement for outpatient services is based on a facility's contractual agreement in effect at the time services are rendered. To receive payment, facilities must properly identify services provided by submitting a completed UB 04 (or successor), or other HIPAA-compliant claim form and include all applicable codes (Revenue, CPT/HCPCS, modifiers) for each service. Revenue Codes should be appropriate for the bill type.

Blue Shield periodically reviews, and makes appropriate updates to, procedure listings based on industry standards. Updated listings are provided electronically and available upon request. Please consult your Blue Shield Network Manager for verification of your negotiated payment schedule.

Blue Shield reimburses facilities for outpatient services rendered to Blue Shield members using a variety of payment terms, including but not limited to: case rates, per visit rates, fee schedules, APC payment rate, and percentage of charges. In calculating allowed amounts, Blue Shield may round the figure to the nearest whole dollar. Please refer to your agreement to determine the reimbursement structure applicable to each outpatient service.

To complement the agreement, each section below provides:

A. A summary of the reimbursement method
B. A calculation example(s)

For outpatient services reimbursed pursuant to the APC payment rate, please refer to Section X of this document.

I. OUTPATIENT SURGICAL SERVICES

A. Summary

Blue Shield has implemented a payment system for outpatient surgical services that classifies ambulatory procedures into related groups. The groups are based on the relative resource needs (costs) for that group of procedures. The core of this payment system is the CPT-specific coding. Facilities must bill with appropriate revenue codes, CPT/HCPCS codes and modifiers in order to receive applicable payment. Blue Shield reimburses facilities for outpatient surgical services using one of the following payment methodologies:

- **Outpatient Surgical Grouper Schedule**
- **APG Payment Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules,* then *View facility fee schedules*. Instructions are provided as well as a link to the *Provider Name Fee Schedule Crosswalk* that identifies the specific fee schedule assigned to you.

You may also request a CD version of the updated fee schedule(s) be mailed to you by emailing facilityfeeschedules@blueshieldca.com.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

I. OUTPATIENT SURGICAL SERVICES *(cont'd.)*

B. Examples of Reimbursement Calculation

Facilities contracting with Blue Shield under the Outpatient Surgical Grouper Schedule or APG Payment Schedule methodologies utilize reimbursement calculations resembling the examples below.

Outpatient Surgical Grouper Schedule

SURGICAL SERVICES OUTPATIENT SURGICAL GROUPER SCHEDULE CALCULATION EXAMPLE	
Formula	Facility Payment = (Outpatient Surgical Group Index Fee) x (Regional Factor) x (Multiplier)
Example Assumptions	• Revenue code billed is 0360 • CPT code billed is 10022 • CPT code 10022 is assigned to Outpatient Surgical Group 1 • Outpatient Surgical Group 1 has an **Outpatient Surgical Index Fee** of **$340** • Hospital is in XYZ county, which has a **Regional Factor** of **1.176** • Hospital's negotiated **Multiplier** is **2.00**
Total Case Rate Payment = $340 x 1.176 x 2.00 = (The case rate payment may be rounded to the nearest whole dollar.)	**$799.68**

APG Payment Schedule

SURGICAL SERVICES APG PAYMENT SCHEDULE CALCULATION EXAMPLE	
Formula	Facility Payment = (APG Grouper (corresponding APG Weight)) x (APG Payment Rate)
Example Assumptions	• Revenue code billed is 0360 • CPT code billed is 10021 • CPT code 10021 is assigned to Grouper 001 • Grouper 001 has a **weight** of **0.2000** • Hospital's negotiated value of **APG at 1.0000** (APG Payment Rate) is **$1,000**
Total Case Rate Payment = 0.2000 x $1,000 = (The case rate payment may be rounded to the nearest whole dollar.)	**$200**

II. OUTPATIENT EMERGENCY SERVICES AND URGENT CARE SERVICES

A. Summary

Reimbursement for Emergency Services is based on the level of care provided to a Blue Shield member. Level of care varies from Level 1 (Limited) to Level 4 (Critical). Facilities must bill with applicable revenue codes, CPT/HCPCS codes and modifiers in order to receive reimbursement.

Blue Shield reimburses facilities for outpatient Emergency Services and Urgent Care Services using, generally, one of the following payment methodologies:

- **Case Rate**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required revenue and CPT/HCPCS codes.

B. Example of Reimbursement Calculation

Facilities contracting with Blue Shield under the case rate methodology utilize reimbursement calculations resembling the example below.

EMERGENCY SERVICES AND URGENT CARE SERVICES CASE RATE CALCULATION EXAMPLE		
Formula	Facility Payment = (Case Rate) x (Multiplier)	
Example Assumptions	• Revenue code billed is 0450 • CPT Code billed is 99281, which is Level 1: Limited • The **Case Rate** for Level 1 is **$97** • Hospital's negotiated **multiplier** is **2.00**	
Total Case Rate Payment = $97 x 2.00 = (The case rate payment may be rounded to the nearest whole dollar.)		**$194**

III. DIALYSIS SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Dialysis Services using one of the following payment methodologies:

- **Per Visit Rate (excluding Pharmaceuticals)**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes.

B. Example of Reimbursement Calculation

For Facilities Under a Per Visit Rate Agreement

For each day of, or visit for, Dialysis covered services provided on an outpatient basis by a facility to a member, Blue Shield will pay the facility the per visit rate multiplied by the negotiated dialysis multiplier, as set forth in your agreement.

Please see Section VIII, Outpatient Pharmaceutical Services, for specific details and calculation examples regarding pharmaceutical reimbursement.

Facilities contracting with Blue Shield under the per visit rate methodology utilize reimbursement calculations resembling the example below.

DIALYSIS SERVICES PER VISIT RATE CALCULATION EXAMPLE		
Formula	Facility Payment = (per visit rate) x (Multiplier)	
Example Assumptions	• Revenue code billed is 0829, which is Mobile Dialysis • The **per visit rate** for Mobile Dialysis is **$300** • Hospital's negotiated **Multiplier** is **1.10**	
Total Per Visit Payment = $300 x 1.10 = (The per visit payment may be rounded to the nearest whole dollar.)		**$330**

IV. OUTPATIENT INFUSION THERAPY SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Infusion Therapy Services using one of the following payment methodologies:

- **Per Visit Rate (excluding Pharmaceuticals)**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes.

Compensation for the facility's provision of outpatient Infusion Therapy Services provided to HMO or Medicare Advantage members is generally the financial responsibility of the member's IPA or medical group.

B. Example of Reimbursement Calculation

For Facilities Under a Per Visit Rate Agreement

For each day of, or visit for, Infusion Therapy covered services provided on an outpatient basis by a facility to a member, Blue Shield will pay the facility the per visit rate.

Please see Section VIII, Outpatient Pharmaceutical Services, for specific details and calculation examples regarding pharmaceutical reimbursement.

Facilities contracting with Blue Shield under the per visit rate methodology utilize reimbursement calculations resembling the example below.

INFUSION THERAPY SERVICES PER VISIT RATE CALCULATION EXAMPLE		
Formula	Facility Payment = the per visit rate set forth in the agreement	
Example Assumptions	• Revenue code billed is 0261, which is an Infusion Therapy revenue code • Hospital's negotiated **per visit rate** is **$250**	
Total Per Visit Payment =		**$250**

V. OUTPATIENT PHYSICAL, RESPIRATORY, SPEECH, AND OCCUPATIONAL THERAPY SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Physical, Respiratory, Speech, and Occupational Therapy Services using one of the following payment methodologies:

- **Per Visit Rate**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes.

Compensation for the facility's provision of outpatient Physical Therapy, Respiratory Therapy, Speech Therapy, and Occupational Therapy Services provided to HMO or Medicare Advantage members is generally the financial responsibility of the member's IPA or medical group.

B. Example of Reimbursement Calculation

For Facilities Under a Per Visit Rate Agreement

For Physical, Respiratory, Speech, and Occupational Therapy covered services provided by the facility to a member, Blue Shield will pay the facility the per visit rate.

Facilities contracting with Blue Shield under the per visit rate methodology utilize reimbursement calculations resembling the example below.

RESPIRATORY THERAPY SERVICES PER VISIT RATE CALCULATION EXAMPLE		
Formula	Facility Payment = the negotiated per visit rate set forth in your agreement	
Example Assumptions	• Revenue code billed is 0412, which is a Respiratory Therapy revenue code • Hospital's negotiated **per visit rate** is **$75**	
Total Per Visit Payment =		**$75**

VI. OUTPATIENT RADIOLOGY, PATHOLOGY, AND DIAGNOTIC TEST SERVICES

A. Summary

For the facility and technical component of covered outpatient Radiology, Pathology, and Diagnostic Test Services provided by the facility to a member, Blue Shield reimburses facilities in accordance with the following methodologies:

- **Outpatient Radiology, Pathology, and Diagnostic Test Services Fee Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules,* then *View facility fee schedules*. Instructions are provided as well as a link to the *Provider Name Fee Schedule Crosswalk* that identifies the specific fee schedule assigned to you.

You may also request a CD version of the updated fee schedule(s) be mailed to you by emailing facilityfeeschedules@blueshieldca.com.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

B. Example of Reimbursement Calculation

For agreements with diagnostic services reimbursed under fixed payment methodologies, the following formulas are used to calculate reimbursements:

OUTPATIENT RADIOLOGY, PATHOLOGY, AND DIAGNOSTIC TEST SERVICES FEE SCHEDULE	
Formulas	Facility Payment = (a + b) x (Conversion Factor) x (Multiplier) *where:* (a) = (Practice Expense Technical Component based on the Outpatient Radiology, Pathology and Diagnostic Tests Schedule) x (Practice Regional Factor for the region in which the hospital facility providing the service is located) *(subject to rounding)* (b) = (Malpractice Expense Technical Component based on the Outpatient Radiology, Pathology and Diagnostic Tests Schedule) x (Malpractice Regional Factor for the region in which the hospital facility providing the service is located) *(subject to rounding)*
Example Assumptions	• Revenue code billed is 0310 • CPT code billed is 70470, which has the following values: - **Practice Expense Technical Component = 7.100** - **Malpractice Expense Technical Component = 0.370** • County is XYZ has the following factors: - **Practice Regional Factor = 1.235** - **Malpractice Regional Factor = 0.669** • **Conversion Factor = $40.6978** • Hospital's negotiated **Multiplier is 1.00**
Calculating (a): (a) = (7.100 x 1.235) = 8.7685	
Calculating (b): (b) = (0.370 x 0.669) = 0.24753	
Payment = (8.7685 + 0.24753) x ($40.6978) x (1.00) = (9.01603) x ($40.6978) x (1.00) = (The payment may be rounded to the nearest whole dollar.)	**$366.93**

VII. OUTPATIENT CLINICAL LABORATORY SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Clinical Laboratory Services using one of the following payment methodologies:

- **Clinical Laboratory Fee Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules,* then *View facility fee schedules*. Instructions are provided as well as a link to the *Provider Name Fee Schedule Crosswalk* that identifies the specific fee schedule assigned to you.

You may also request a CD version of the updated fee schedule(s) be mailed to you by emailing facilityfeeschedules@blueshieldca.com.

If you have questions about updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

B. Example of Reimbursement Calculation

For Facilities Using a Clinical Laboratory Fee Schedule

For the facility and technical component of all outpatient laboratory covered services provided by the hospital to a member, Blue Shield will pay the facility using the Clinical Laboratory Fee Schedule multiplied by the negotiated Hospital Specific Multiplier, as set forth in your agreement.

Facilities contracting with Blue Shield under the Clinical Laboratory Fee Schedule methodology utilize reimbursement calculations resembling the examples below.

CLINICAL LABORATORY SERVICES CLINICAL LABORATORY SCHEDULE CALCULATION EXAMPLE	
Formula	Facility Payment = (Clinical Laboratory Fee Schedule Rate) x (Multiplier)
Example Assumptions	• Revenue code billed is 0300 • CPT code billed is 80053 • The **Clinical Laboratory Fee Schedule** rate for this CPT code is **$14.77** • Hospital's negotiated **Multiplier** is **2.00**
Total Payment for CPT code 80053 = $14.77 x 2.00 = (The calculation may be rounded to the nearest whole dollar.)	**$29.54**

VIII. OUTPATIENT PHARMACEUTICAL SERVICES

A. Summary

Blue Shield reimburses facilities for outpatient Pharmaceutical Services using the following payment methodologies:

- **Outpatient Pharmaceutical Fee Schedule**
- **Percentage of Charges**

Please refer to your agreement to determine which payment methodology applies to your facility and to view a complete listing of required Revenue and CPT/HCPCS Codes. If your facility is reimbursed under a fee schedule methodology, please see your fee schedule for a complete listing of CPT/HCPCS Codes.

Blue Shield's AWP-based Outpatient Pharmaceutical Fee Schedule is updated quarterly to capture changes to AWP pricing. To access your fee schedule, you can search and download the updated files on Provider Connection at www.blueshieldca.com/provider under *Claims, Facility and professional fee schedules, View facility fee schedules,* then *Pharmaceutical fee schedules.*

If you have questions about these updates to the fee schedules, please contact your Blue Shield Provider Relations Coordinator.

B. Example of Reimbursement Calculation

For Facilities Using the Outpatient Pharmaceutical Fee Schedule

The Blue Shield Outpatient Pharmaceutical Fee Schedule is based on the Average Wholesale Price (AWP). The AWP shall be derived from nationally recognized pricing sources selected by Blue Shield and shall be updated by Blue Shield quarterly. For new drugs, or drugs that are unclassified, the facility must bill using the appropriate revenue code, unclassified CPT-4/HCPCS code, and NDC Code with description in order to receive payment.

Facilities contracting with Blue Shield under the Pharmaceutical Fee Schedule methodology utilize reimbursement calculations resembling the example below.

PHARMACEUTICAL SERVICES OUTPATIENT PHARMACEUTICAL FEE SCHEDULE CALCULATION EXAMPLE		
Formula	Facility Payment = (Outpatient Pharmaceutical Fee Schedule) x (number of units)	
Example Assumptions	• HCPCS code billed is J0282 • The **Outpatient Pharmaceutical Fee Schedule** rate for J0282 is **$1.39** per unit • **Units billed** = **5**	
Total Payment = $1.39 x 5 = (The payment may be rounded to the nearest whole dollar.)		**$6.95**

IX. OTHER OUTPATIENT SERVICES

A. Summary

Blue Shield will compensate the facility for other covered outpatient services provided to a member not referenced under any specific outpatient services payment category at allowed charges minus the negotiated discount percentage. In many cases, reimbursement for these services will not exceed the Medical/ Surgical/ Pediatric Per Diem Rate set forth in your agreement.

Please review your agreement's specific terms for details.

X. OUTPATIENT SERVICES REIMBURSED AT APC PAYMENT RATE

A. Summary

Blue Shield reimburses pursuant to the Outpatient Fee Schedule using the following payment methodologies:

- **Outpatient Pharmaceutical Fee Schedule**
- **Percentage of Charges**

B. Example of Reimbursement Calculation

Services Assigned a Rate on the Outpatient Fee Schedule

OUTPATIENT FEE SCHEDULE ASSIGNED RATE CALCULATION EXAMPLE		
Formula	Facility Payment = (Outpatient Fee Schedule) x (Multiplier)	
Example Assumptions	• CPT code billed is 20999 • The rate for CPT code 20999 is $1500 • Hospital's Multiplier is 1.05	
Total Payment = $1,500 x 1.05 = $1,575 (The payment may be rounded to the nearest whole dollar)		**$1,575**

Services Reimbursed at POC Pursuant to the Outpatient Fee Schedule

OUTPATIENT FEE SCHEDULE POC CALCULATION EXAMPLE		
Formula	Facility Payment = (Allowed Charges) x (Base) x (Multiplier)	
Example Assumptions	• CPT code billed is 58150 • Hospital's Allowed Charges are $2,000 • Hospital's Base Percentage is 10.2% • Hospital's Multiplier is 1.05	
Total Payment = $2,000 x 10.2% x 1.05 = $2,000 x .102 x 1.05 = (The payment may be rounded to the nearest whole dollar)		**$214.20**

Skilled Nursing Facility Discharges (SNF or TCU)

Background

There have been longstanding federal regulations designed to protect member rights for Medicare Advantage (MA) enrollees. These regulations include the right to due process, with appeal rights when any service or item being denied or, as cited in Section 422.568(c) of the Balanced Budget Act, when a discontinuation of a service occurs and the member disagrees.

For skilled nursing facility discharges, discontinuation of service, continued stay beyond the maximum Medicare / Blue Shield Medicare Advantage plan covered benefit of 100 days per benefit period, a specific, regulatory notice is required to be provided to the beneficiary (member) (or legal representative) and said notice requires a signed acknowledgement of receipt.

What constitutes a valid acknowledgement of receipt?

The Centers for Medicare & Medicaid Services (CMS) has external review performed through Maximus Federal Services (Maximus). We are summarizing from Maximus "Reconsideration Notes", the guidelines for appropriate notice of receipt of the Notice of Non-Coverage (NONC) for SNF discharges. Signature validates receipt of the notice, but does not imply any agreement. The notice ties to delivery of member rights and for a notice to be considered to have occurred, the following guidelines apply:

Delivery in person is preferable and the member must sign the actual notice. For appeals cases, the plan must provide a copy of the actual notice delivered, not a sample letter, along with the signature page, with the member signature, acknowledging receipt.

If a member refuses to sign an acknowledgment of receipt of the Notice of Non-Coverage, both the beneficiary's medical chart and the "refusal to sign" page of the notice should reflect:

- The date the notice was delivered.
- The individual who delivered the notice.
- Specific reasons for the member's refusal to sign the notice receipt acknowledgment form.
- If a witness is able to attest a patient's refusal to sign, document the delivery of the notice and obtain the witness's signature as attestment to the patient's refusal to sign.
- If a witness is not available, the individual delivering the notice should sign the acknowledgment form to attest the attempted delivery of the Notice of Non-Coverage.

Enhancements to build on the acknowledgment of receipt in the case of a refusal to sign:

- Often, a verbal notice of a planned discharge occurs prior to delivery of the actual written notice. Although not required, if a verbal notice occurs, it can be easily noted on the Acknowledgment of Receipt page prior to delivery of the notice to the member. By noting the verbal notice on the acknowledgment of receipt, the case documentation is enhanced, should an issue be subsequently appealed. NOTE: Verbal notice does not meet the requirements for valid notice. Verbal notice can only be used to enhance the case documentation related to the actual delivery of a valid notice with a signed acknowledgement of receipt.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Guardians and Incompetent Patients

A Notice is not valid if delivered knowingly to an incompetent patient. Having a patient being discharged from skilled nursing care with a diagnosis of dementia is not likely to hold as a valid notice on appeal unless there are documented attempts to also deliver the Notice of Non-Coverage (NONC) to and secure a signed acknowledgment from any legal guardian or other family members.

Legal guardians include court appointed guardians, family members with Durable Power of Attorney for Health Care, or appropriate legal counsel/attorney representation. Additionally, it is also recognized that, as a practical matter, there are circumstances when appointment documentation cannot be obtained in a timely manner. If a member is not competent or is physically unable to sign the statement, and the representative is the spouse or next of kin, the notice acknowledgement that is signed by a default representative should be clearly documented by the facility as to the applicability of a state allowable person to be a default representative. In the event there is any controversy related to such default representation, only a representative as determined by the appropriate state court would be accepted.

If verbal or telephonic notice is provided to a representative, this is only as back up to the actual signed acknowledgement of written notice. The member officially receives notice when the written notice is delivered and a signed acknowledgement obtained or a clearly documented refusal to sign the acknowledgement occurs.

We are challenged when a guardian is unwilling to sign the acknowledgment of receipt of the notice and direct hand delivery is not viable. In such cases, document all attempts to both verbally inform and to physically deliver the notice carefully. If delivery of the notice to a guardian for an incompetent patient is via mail, keep all receipts from the courier service or certified mail (return receipt required) to demonstrate delivery of the notice. In such cases, the signed courier service or other confirmation of delivery can be submitted as valid acknowledgement of receipt.

- The patient's chart should document any verbal notice
- Document attempted delivery to member and guardian
- Obtain signed acknowledgement of receipt or document (and preferably witness) actual delivery of the notice, where there is a refusal to sign

Note: In cases where care must be coordinated through an offsite guardian, provide adequate time for delivery of a valid notice. (A courier service delivery will delay notice and potentially discharge by only one day, if they are able to deliver to the guardian. U.S. Certified mail is not as predictable.)

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes and the Centers for Medicare & Medicaid Services

Important Notice: The Grijalva Final Rule 42 C.F.R. § 422.620 contains provisions required under the settlement agreement in the Grijalva v. Shalala litigation concerning appeal rights under the Medicare managed care program to Medicare Advantage (MA) enrollees at the time of discharge from an inpatient hospital stay. For the Grijalva portion, which relates to SNF, Home Health and CORF discharges, the effective date was January 1, 2004. The current requirement still in effect for IPAs is to deliver the Notice of Non-Coverage (NONC) within one day prior to the effective date of the discharge.

The Final Rule Requires:

- The right to an immediate review of a Medicare Advantage Organization (MAO) discharge decision by an independent review body if the enrollee believes services should continue.
- Advanced written notice to all MA enrollees **at least two days before** the termination of certain services (before planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services), with instructions on how to obtain a detailed notice and file an appeal.
- Upon request, a specific and detailed explanation of why services are either no longer medically necessary or are no longer covered by the health plan. The health plan also needs to describe any applicable Medicare coverage rule, MA policy, contract provision or rationale upon which the termination decision was based.

In addition, the final rule requires MAOs to provide detailed discharge notices only in those situations where enrollees indicate dissatisfaction with the health plan's decision. All Medicare beneficiaries who are treated in a hospital will continue to receive generic notices upon admission that will inform them of their appeal rights, but only those beneficiaries that disagree with the decision to be discharged must be issued a detailed written notice of non-coverage one day before their hospital coverage ends. If an appeal is filed, beneficiaries remain entitled to continuation of coverage for their hospital stay until the quality improvement organization renders a decision.

Enrollees then may request an independent review of the MA organization's decision to end coverage of SNF, HHA or CORF services. In the event of a timely appeal request, an MA organization must issue a second, detailed notice that explains the reasons why Medicare coverage should end.

CMS has designated Quality Improvement Organizations (QIOs) to conduct these fast-track reviews. QIOs are suitable for the fast-track appeals process in light of their experience in performing similar, immediate reviews of inpatient hospital discharges. The QIO that has an agreement with the SNF, HHA, or CORF providing the enrollee's services will process the appeal. The MA organization must provide the second, detailed notice to both the QIO and the enrollee.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

Provider Notification of Termination. An important feature of the final rule provisions is that Medicare would charge providers with the actual delivery of the required notices. CMS believes that the providers themselves are in the best position to deliver the notices to enrollees, and that it would be placing an unreasonable burden on MAO's to require that they deliver the notices to affected enrollees. The MA organization would retain ultimate responsibility for the decision to terminate services and for financial coverage of the services, however. The services would remain covered until four calendar days after an enrollee receives the termination notice, or if the Independent Review Entity reviews the decision, until noon on the day after an Independent Review Entity decision upholding the MAO's decision. CMS believes that the requirement that providers issue these notices, in effect on behalf of MAO's, best ensures that beneficiaries receive these notices in a timely manner. To facilitate implementation of this policy, we are proposing under §422.502(I) that all contracts between MAO's and their providers must specify that the providers will comply with the notice and appeal provisions in subpart M of the federal requirements.

Timing of Notices. Section 422.624(b)(1) addresses the timing of the required notices. In general, the provider would notify the enrollee of the MAO's decision to terminate covered services two calendar days before the scheduled termination. Again, the current requirement still in effect is within one day of the date of discharge. If the provider services are expected to be furnished to an enrollee for a time span of fewer than two calendar days in duration, the enrollee should be given the notice upon admission to the provider (or at the beginning of the service period if there is no official ''admission'' to a non-institutional provider, such as in an HHA setting). The notice must be given in all situations, regardless of whether an enrollee agrees with the decision that his or her services should end.

CMS would allow providers a full working ''day'' within which to deliver the termination notice, with any notification delivered during normal business hours on a given day serving to initiate the four-day standard on that day, even if the timing of the delivery of the notice resulted in fewer than 24 hours to ask for an Independent Review Entity appeal, and fewer than 96 hours between notification and the proposed termination of services. That is, a notice delivered to a member at 2 p.m., Monday, would indicate that the member has until noon, Tuesday, to appeal to the Independent Review Entity, with termination of services scheduled for noon, Friday.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

Delivery of Notices. §422.624(c) specifies that ''delivery'' of a notice is valid only if a member has signed and dated the notice to indicate that he or she both received the notice and can comprehend its contents. This policy is consistent with our requirements governing delivery of similar notices, such as the requirements set forth in HCFA Program Memoranda A-02-018 for HHA Advanced Beneficiary Notices. Under this concept, a member who is comatose, confused, or otherwise unable to understand or act on his or her rights could not validly ''receive'' the notice, necessitating the presence of an authorized representative for purposes of receiving the notice. Similarly, presenting the standardized notice to a person who is illiterate, blind, or unable to understand English would not constitute successful ''delivery'' of the notice. Such situations could be remedied either through use of an authorized representative if that person has no barriers to receiving the notice or through other steps (such as use of a translator or language accessible version of the notice) that overcome the difficulties associated with notification.

Note: CMS would not interpret the requirement for successful delivery to permit an enrollee to extend coverage indefinitely by refusing to sign a notice of termination. If an enrollee refuses to sign a notice, the provider would annotate its copy of the notice to indicate the refusal, and the date of the refusal would be considered the date of receipt of the notice. Paragraph (c) describes what constitutes an effective delivery of a termination notice. The notice would have to be delivered timely, using standardized format and language, and include all of the elements required under §422.624(b)(2).

BLUE SHIELD OF CALIFORNIA
APPEAL PROCESS FOR NOTICE OF NON-COVERAGE HHA, SNF, CORF

#	Responsible Party	Activity	Time Requirement
___	MSO	Determines termination date and drafts Notice of Medicare Non-Coverage (NOMNC). Faxes to SNF, HHA, CORF. If SNF, HHA, CORF prepare their own notices then notification needs to be given for termination date.	No less than 2 days prior to termination of services
1.	SNF, HHA, CORF	Issues NOMNC and obtains member's signature. SNF- at least 2 days prior to termination If < 2 days of service, then on admission or first visit, if the enrollee's services are expected to be fewer than 2 days in duration, the SNF, HHA, or CORF should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the provider should deliver the notice no later than the next to last time that services are furnished. If benefits are exhausted a notice is required, the member may appeal, however these are referred back to the health plan to review and respond to this appeal. If a HHA is going out for an evaluation only, the agency is not required to send a notice. Also when only partial services are being discontinued (i.e., PT ends, but HHC continues), no notice is needed until all services end.	2 days prior to termination of services

Blue Shield Medicare Advantage Plan
Required Billing Elements

#	Responsible Party	Activity	Time Requirement
2.	Enrollee	Disagrees with the discharge, the enrollee must contact the Quality Improvement Organization (QIO), Health Services Advisory Group, Inc. This request is made either in writing, telephone or fax, by noon the day after receipt of the NOMNC. The notice is still considered timely as long as Health Services Advisory Group, Inc. receives the appeal request no later than noon the day before the effective date that Medicare coverage ends.	No later than noon the day after receipt of notice
3.	QIO = Health Services Advisory Group, Inc.	Receives Appeal request from enrollee or representative. Immediately notifies Medicare Advantage and the provider of the enrollee's request for a fast track appeal by phone and fax.	Day 1 begins
4.	MA (Medicare Advantage) = Medicare Advantage plan	Receives notice of appeal from Health Services Advisory Group, Inc. (by phone & fax) requesting the following information for review: A copy of the advance notice of termination (NONMC), a copy of the detailed explanation of Non-coverage (DENC), a copy of enrollee's medical records, and a copy of other documents as requested.	Day 1
5.	Blue Shield Medicare Advantage plan	Contact CM at IPA/MSO and request the information above faxed to Health Services Advisory Group, Inc. for review. Advise of same day requirement for sending these records. Request coversheet confirming records were sent to Health Services Advisory Group, Inc., copy of NONMC and DENC faxed to Blue Shield Medicare Advantage plan. Also contact should be made to SNF requesting records & NOMNC be faxed to Health Services Advisory Group, Inc. for review with confirmation of this to Blue Shield. Health Services Advisory Group, Inc. needs the detailed chart notes that SNF's have for review.	Day 1
6.	Blue Shield Medicare Advantage plan	If IPA/MSO is unable to make Day 1 submission requirement, notify Manager, Director or Medical Director	Day 1
7.	Blue Shield Medicare Advantage plan	Manager, Director or Medical Director then contacts IPA Director of UM/QM & or Medical Director to obtain documents.	Day 1
8.	IPA/MSO	Faxes records to: 1.) Health Services Advisory Group, Inc. Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee's medical records. 2.) Member/representative: Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.	Day 1

#	Responsible Party	Activity	Time Requirement
9.	IPA/ Blue Shield Medicare Advantage plan	HMO ONLY: IPA makes decision to rescind the termination date and send new letter to member Fax copy of letter to Health Services Advisory Group, Inc. PPO ONLY: Blue Shield makes decision to rescind the termination date and send new letter to member Fax copy of letter to Health Services Advisory Group, Inc	Resolved Go to step 14 Resolved Go to step 14
10.	Health Services Advisory Group, Inc.	Reviews documents Renders decision to uphold or overturn Notifies Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 1 If Resolved Go to step 14
11.	Health Services Advisory Group, Inc.	If documents not received by Health Services Advisory Group, Inc., on Day 2, Health Services Advisory Group, Inc. sends to Blue Shield Medicare Advantage plan , "Notice: Failure to Comply" requesting documents again.	Day 2
12.	Blue Shield Medicare Advantage plan	Call IPA/MSO contact again to ensure all documents are faxed to Health Services Advisory Group, Inc. for review.	Day 2
13.	Health Services Advisory Group, Inc.	Review documents Render decision to uphold or overturn Notifies IPA & Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 2
14.	Blue Shield Medicare Advantage plan	Logs all actions, dates & times in Notes document Prepare file for each appeal with notes on left side of folder, all other documents are filed on right side of folder, latest on top Record case in Grijalva Appeals tracking log	Real time
15.	Blue Shield Medicare Advantage plan	Cases are filed away in a locked cabinet alphabetically	Conclusion

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Contractual and Billing Requirements

Contracts already obligate providers to compliance with state and federal regulations. As part of the new CMS rule, contracted entities must comply with applicable notice and appeal provisions in subpart M, including but not limited to, the notification requirements in §§422.620 and 422.624 and the requirements in §422.626 concerning supplying information to an Independent Review Entity.

Questions & Answers:

- **Is the provider or MA organization required to obtain an enrollee's signature on the advance termination notice or detailed termination notice?**
  The provider must obtain the enrollee's or authorized representative's signature on the advance termination notice (NOMNC), which ensures that the enrollee received the notice, and that financial liability may be properly transferred to the enrollee for any days beyond the effective date that Medicare coverage ends. The provider must place the original NOMNC in the enrollee's case file, and give a copy to the enrollee. In the event of an appeal, the provider must also provide a copy to the Quality Improvement Organization (QIO), since the QIO is responsible for verifying that the provider delivered a valid notice to the enrollee.

  The MA organization does not need to obtain the enrollee's or authorized representative's signature on the detailed notice, which is called the Detailed Explanation of Non-Coverage (DENC).

- **Suppose that an enrollee is receiving physical therapy, wound care, and IV in a SNF. If the SNF only discontinues the IV, is the SNF required to deliver an NOMNC to the enrollee two days prior to the IV ending?**
  No. A provider is not required to deliver the NOMNC two days prior to one service ending, while other Medicare-covered services continue. The fast-track appeals process applies only to situations when the enrollee will no longer receive Medicare-covered services from the provider. The scenario described would be considered a reduction, rather than a termination, of services.

- **Many patients receiving home health care only require a single visit. Can the NOMNC be given during the first (and last) visit?**
  Yes. In cases where the services or visits will be less than two days, the NOMNC may be given upon admission, or during the only visit.

- **If a member is in a SNF, gets pneumonia and subsequently needs to go to an acute setting, should the member receive the NOMNC?**
  No. The NOMNC is not intended or required for this situation.

- **Will SNFs, HHAs, and CORFs be required to retain copies of NOMNCs in patients' medical records? Will the MA organization need to obtain a copy?**
  The provider should retain a copy of the NOMNC as part of the patient's medical record; however, MAO's and providers should determine how and where the notices should be maintained to meet medical records' retention policies.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Contractual & Billing Requirements *(cont'd.)*

- **If a provider is discontinuing a previously authorized, discrete increment of services, e.g., the MA organization authorized 12 skilled nursing visits by an HHA nurse, does the provider still have to issue a NOMNC if the provider is planning to discharge the patient as scheduled on the last visit? Why?**
  Yes. The provider must deliver the NOMNC no later than the next-to-last visit in this example. Providing a notice to the enrollee not only conveys when the services are going to end, but also informs the enrollee of the right to appeal if the enrollee disagrees, and transfers liability to the enrollee if the enrollee continues to receive non-covered services.

- **Can you please clarify if whether the fast-track appeals process also includes psychiatric home health services?**
  Yes, the fast-track appeals process applies to psychiatric home health services.

- **How will providers know what their responsibilities are under the new fast-track appeals process?**
  CMS provides information to providers on their responsibilities under this new appeals process through CMS' Medlearn website, CMS' "list serve" of participating providers, outreach to provider trade associations, and CMS open door forums. In addition, we are instructing our fiscal intermediaries and carriers to include an article about the process in their next provider bulletins. QIOs also are required to provide education and training to the providers with whom they have agreements. MAO's must also do their part to ensure that their providers are educated about their responsibilities under the fast-track appeals process.

- **Will CMS release the NOMNC to providers, or will MAO's be required to distribute the notices to the providers directly?**
  The notices are available online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices. MAO's should work with their providers to determine whether direct distribution is necessary. The provider education material that we have distributed refers providers to the "appeals" website.

Blue Shield Medicare Advantage Plan
Required Billing Elements

CMS Model Letters:

- **DETAILED NOTICE OF DISCHARGE (Attachment A)**
- **NOTICE OF MEDICARE NON-COVERAGE (Attachment B)**

(Attachment A – CMS Model Letter – **SAMPLE -** Must be 12 point font)

Patient Name: **OMB Approval No. 0938-1019**
Patient ID Number: Date Issued:
Physician:

{Insert Hospital or Plan Logo here}
DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on _____. This is based on Medicare coverage policies listed below and your medical condition.
This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

  ____Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

  ____Medicare Managed Care policies, if applicable:_____
  {insert specific managed care policies}

  ____Other _____
  {insert other applicable policies}

- Specific information about your current medical condition:
- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call **{insert hospital and/or plan telephone number}**.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938- 1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. CMS 10066 (approved 5/2007)

(Attachment B – CMS Model Letter – **SAMPLE -** Must be 12 point font)
OMB Approval No. 0938-0953

{Insert provider contact information here}

NOTICE OF MEDICARE NON-COVERAGE

Patient name: **Patient number:**

The Effective Date Coverage of Your Current {insert type}
Services Will End: {insert effective date}

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above.
- Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Health Services Advisory Group of California, Inc., 1-800-841-1602, TTY 1-800-881-5980, to appeal, or if you have questions.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953
H0504_12_095B File & Use 05052012

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information:

Blue Shield Medicare Advantage Plan
Attn: Medicare Appeals and Grievances Dept.
P.O. Box 927
Woodland Hills, CA 91365-9856

Ph: 1-800-776-4466
TTY: 1-800-794-1099
Fax: 1-916-350-6510

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative Date

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

Optional Attachment to assist with documentation

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to:

_____

CONFIRMATION OF NOTICE BY TELEPHONE

(Notification by telephone is done only in situations where the notice must be delivered to an incompetent enrollee in an institutional setting. See *Medicare Managed Care Manual*, Chapter 13, Section 60.1.3 for reference.)

Name of person contacted:

Date of contact: Time: ☐AM ☐PM

_____ _____

Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative Date

CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL

(Notification by mail must also be done if telephone notification was made. This is done only in situations where the notice must be delivered to an incompetent enrollee is in an institutional setting. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)

Mailing address:

_____

_____

Date sent: _____Via: ☐ US Mail ☐ Certified Mail ☐ FedEx ☐ Priority Mail

_____

Tracking # (if applicable): _____

CONFIRMATION OF REFUSAL TO SIGN

I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the member or the member's authorized representative; however, the member or the member's authorized representative refused to sign the acknowledgment of receipt.

Name of person receiving notice:

Date of delivery: Time: ☐AM ☐PM

_____ _____

Signature of Person Delivering Notice Date

_____ _____

Blue Shield Medicare Advantage Plan
Required Billing Elements

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	BSC/MG/ IPA			
Call patient's representative the day letter is issued. (Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g., QIO vs. expedited).					
Inform representative that skilled services will no longer be covered beginning on: (date) _____ and financial responsibility starts on (date) _____					
Advise representative of appeal rights. (You must read directly from the letter)					
Advise representative that an appeal must be phoned to HSAG by 12:00 p.m. the following day of receipt of the NOMNC or phone call.					
Provide the representative with the QIO name (HSAG) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.					
Inform representative how to get a detailed notice describing why the enrollee's services are not being covered					
Provide at least one phone number of an advocacy organization or 1-800-MEDICARE					
Confirm the telephone contact by written notice mailed same day.					
If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. (If the **Medical Group** is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.) (If the **Facility** sent the certified mail, and HSAG is processing an appeal, the certified returned receipt must be submitted to HSAG. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)					
Document that representative understands the information provided.					

Where to Send Claims

Hospitals and facilities are asked to submit Blue Shield claims electronically that do not have a medical record attached. Electronically submitted claims will be acknowledged within 2 days. Claims are submitted in the ASC X12 837 5010 format. Blue Shield has contracted with several vendors for providers to submit claims at no cost. Electronic claims can also be submitted directly to Blue Shield via secure file transfer protocol (SFTP) using one of their own dedicated static IP addresses.

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

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

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

BLUECARD OUT-OF-AREA PROGRAM
Check subscriber ID for three-letter prefix before sending
Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

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

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

BLUE SHIELD MEDICARE ADVANTAGE
Blue Shield Medicare Advantage plan
P. O. Box 272640
Chico, CA 95927
(800) 541-6652
Fax (818) 228-5104

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

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

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

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

Where to Send Claims for Foundations for Medical Care

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

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

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

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

Foundation for Medical Care of Mendocino-Lake Counties

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

List of Incidental Procedures

CPT	DESCRIPTION
10004	Fna bx w/o img gdn ea addl
10006	Fna bx w/us gdn ea addl
10008	Fna bx w/fluor gdn ea addl
10010	Fna bx w/ct gdn ea addl
10012	Fna bx w/mr gdn ea addl
10036	Perq dev soft tiss add imag
11045	Deb subq tissue add-on
11046	Deb musc/fascia add-on
11047	Deb bone add-on
11103	Tangntl bx skin ea sep/addl
11105	Punch bx skin ea sep/ addl
11107	Incal bx skn ea sep/addl
15772	Grfg autol fat lipo ea addl
15774	Each addl 25cc
15777	Acellular derm matrix implt
19030	Injection for breast x-ray
19082	Bx breast add Lesion strtctc
19084	Bx breast add Lesion US imag
19086	BX breast add lesion MR imag
19281	Perq device breast 1st imag
19282	Perq device breast ea imag
19283	Perq dev breast 1st strtctc
19284	Perq dev breast add strtctc
19285	Perq dev breast 1st US imag
19286	Perq dev breast add US imag
19287	Perq dev breast 1st mr guide
19288	Perq dev breast add mr guide
20501	Inject sinus tract for x-ray
20700	Prep and insert drug del device
20701	Removal (deep)
20702	Prep and insert drug del device
20703	Removal (intramedullary)
20704	Prep and insert drug del device
20705	Removal (intra-articular)
20932	Osteoart algrft w/surf & b1
20933	Hemicrt intrclry algrft prtl
20934	Intercalary algrft compl
20985	Cptr-asst dir ms px
21116	Injection, jaw joint x-ray
22552	Addl neck spine fusion
22853	Insj Biomechanical Device
22854	Insj Biomechanical Device
22859	Insj Biomechanical Device
22868	Insj Stablj Dev W/dcmprn
22870	Insj Stablj Dev w/o Dcmprn
23350	Injection for shoulder x-ray
24220	Injection for elbow x-ray

CPT	DESCRIPTION
25246	Injection for wrist x-ray
27093	Injection for hip x-ray
27095	Injection for hip x-ray
27369	Njx Cntrst kne arthg/ct/mri
27648	Injection for ankle x-ray
31627	Navigational bronchoscopy
31649	Bronchial valve remov init
31651	Bronchial valve remov addl
32506	Wedge resect of lung add-on
32507	Wedge resect of lung diag
33508	Endoscopic vein harvest
33866	Aortic hemiarch graft
35572	Harvest femoropopliteal vein
36000	Place needle in vein
36005	Injection ext venography
36010	Place catheter in vein
36011	Place catheter in vein
36012	Place catheter in vein
36013	Place catheter in artery
36014	Place catheter in artery
36015	Place catheter in artery
36100	Establish access to artery
36140	Establish access to artery
36160	Establish access to aorta
36200	Place catheter in aorta
36215	Place catheter in artery
36216	Place catheter in artery
36217	Place catheter in artery
36218	Place catheter in artery
36245	Place catheter in artery
36246	Place catheter in artery
36247	Place catheter in artery
36248	Place catheter in artery
36251	Ins cath ren art 1st unilat
36252	Ins cath ren art 1st bilat
36253	Ins cath ren art 2nd+ unilat
36254	Ins cath ren art 2nd+ bilat
36299	Vessel injection procedure
36400	Bl draw < 3 yrs fem/jugular
36405	Bl draw < 3 yrs scalp vein
36406	Bl draw < 3 yrs other vein
36410	Non-routine bl draw > 3 yrs
36416	Capillary blood draw
36474	Endovenous Mchnchem Add-On
36481	Insertion of catheter, vein
36500	Insertion of catheter, vein
36510	Insertion of catheter, vein

List of Incidental Procedures

CPT	DESCRIPTION
36591	Draw blood off venous device
36592	Collect blood from picc
36600	Withdrawal of arterial blood
36620	Insertion catheter, artery
36625	Insertion catheter, artery
37247	Trluml Balo Angiop Addl Art
37249	Trluml Balo Angiop Addl Vein
37252	Intravasc us noncoronary 1st
37253	Intravasc us noncoronary addl
38200	Injection for spleen x-ray
38790	Inject for lymphatic x-ray
38792	Identify sentinel node
38794	Access thoracic lymph duct
38900	Io map of sent lymph node
42550	Injection for salivary x-ray
44701	Intraop colon lavage add-on
47001	Needle biopsy, liver add-on
49327	Lap ins device for rt
49400	Air injection into abdomen
49412	Ins device for rt guide open
49424	Assess cyst, contrast inject
49427	Injection, abdominal shunt
50606	Endoluminal bx urtr rnl plvs
50684	Injection for ureter x-ray
50690	Injection for ureter x-ray
50705	Ureteral embolization/occl
50706	Balloon dialate urtrl strix
51600	Injection for bladder x-ray
51605	Preparation for bladder xray
51610	Injection for bladder x-ray
51701	Insert bladder catheter
51702	Insert temp bladder cath
54230	Prepare penis study
55300	Prepare, sperm duct x-ray
58340	Catheter for hysterography
61781	Scan proc cranial intra
61782	Scan proc cranial extra
61783	Scan proc spinal
62284	Injection for myelogram
62290	Inject for spine disk x-ray
62291	Inject for spine disk x-ray
64634	Destroy c/th facet jnt addl
64636	Destroy l/s facet jnt addl
64643	Chemodenerv 1 extrem 1 - 4 ea
64645	Chemodenerv 1 extrem 5/> ea
66990	Ophthalmic endoscope add-on
68850	Injection for tear sac x-ray

CPT	DESCRIPTION
69990	Microsurgery add-on
78808	Iv inj ra drug dx study
92973	Percut coronary thrombectomy
92974	Cath place, cardio brachytx
93462	L hrt cath trnsptl puncture
93463	Drug admin & hemodynmic meas
93561	Cardiac output measurement
93562	Cardiac output measurement
93563	Inject congenital card cath
93564	Inject hrt congntl art/grft
93565	Inject l ventr/atrial angio
93566	Inject r ventr/atrial angio
93567	Inject suprvlv aortography
93568	Inject pulm art hrt cath
93571	Heart flow reserve measure
93572	Heart flow reserve measure
95940	Ionm in operating room 15 min
95941	Ionm remote/>1 pt per hour
96904	Whole body photography
96934	Rcm celulr subcelulr img skn
96935	Rcm celulr subcelulr img skn
96936	Rcm celulr subcelulr img skn
0042T	Ct perfusion w/contrast, cbf
0054T	Bone surgery using computer
0055T	Bone surgery using computer
0095T	Each additional interspace
0098T	Each additional interspace
0198T	Ocular blood flow measure
0290T	Laser inc for pkp/lkp recip
0348T	Rsa spine exam
0349T	Rsa upper extr exam
0350T	Rsa lower extr exam
0356T	Insrt drug device for iop
0397T	Ercp w/optical endomicroscpy
0437T	Impltj Synth Rnfcmt Abdl Wal
0439T	Myocrd Contrast Prfuj Echo
0444T	1st Plmt Drug Elut OC Ins
0445T	Sbsqt plmt Drug Elut OC Ins
0466T	Insj ch wal respir eltrd/ra
0471T	Oct skn img acquisj i&r addl
0513T	Esw integ wnd hlg ea addl
0514T	Intraop vis axis id pt fixj
0523T	Ntrapx c ffr w/3d funcil map
0602T	Transdermal GFR Measurements
0603T	Transdermal GFR Monitoring
0604T	Rem Oct Rta Dev Setup & Education
0605T	Rem Oct Rta Tech support Min 8
0615T	Eye movement alys w/o calbrj I&R

List of Incidental Procedures

CPT	DESCRIPTION
A4337	Incontinent rectal insert
A4435	1 pc ost pch drain hgh output
A4555	Ca tx e-stim electr/transduc
A4650	Implant radiation dosimeter
A7027	Combination oral/nasal mask
A9575	Inj gadoterate meglumi 0.1ml
A9581	Gadoxetate disodium inj
A9582	Iodine I-123 iobenguane
A9583	Gadofosveset trisodium inj
C1822	Gen, neuro, hf, rechg bat
C5272	Low cost skin substitute app
C5274	Low cost skin substitute app
C5276	Low cost skin substitute app
C5278	Low cost skin substitute app
C9254	Inj, lacosamide
C9359	Porous purifi colgn matrx bone vd filler
C9363	Skin sub,(meshd wound matrx)
C9364	Porcine implnt (permacol)
C9756	Fluorescence lymph map w/icg
E0766	Elec stim cancer treatment
G2211	Complex e/m visit add on
G2212	Prolong outpt/office visit
G2213	Initiat med assist tx in er
L8604	Inject bulk agent,dextranomer acid,1ml
Q4100	Skin substitute, NOS
Q4101	Apligraf skin sub
Q4102	Oasis wound matrix skin sub
Q4103	Oasis burn matrix skin sub
Q4104	Integra BMWD skin sub
Q4105	Integra DRT skin sub
Q4106	Dermagraft skin sub
Q4107	Graftjacket skin sub
Q4108	Integra matrix skin sub
Q4110	Primatrix skin sub
Q4111	Gammagraft skin sub
Q4112	Cymetra allograft
Q4113	Graftjacket express allograf
Q4114	Integra flowable wound matri
Q4115	Alloskin skin sub
Q4116	Alloderm skin sub
S9433	Medical food oral 100% nutr

List of Incidental Procedures

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List of Office-Based Ambulatory Procedures

CPT	DESCRIPTION
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12011	Repair superficial wound(s)
12013	Repair superficial wound(s)

CPT	DESCRIPTION
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20560	Ndl insert w/o inj 1 or 2 muscles
20561	Ndl insert w/o inj 3 or more muscles
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst
20615	Treatment of bone cyst
20950	Fluid pressure, muscle

List of Office-Based Ambulatory Procedures

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

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

List of Office-Based Ambulatory Procedures

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

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

List of Office-Based Ambulatory Procedures

CPT	DESCRIPTION
64445	N block inj, sciatic, sng
64454	Inj Aa&/Strd Genicular nrv brnch
64455	N block inj, plantar digit
64611	Chemodenerv saliv glands
64615	Chemodenerv musc migraine
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle laryny EMG
64624	Dest Neurolytic agt Genicular nrv
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec

CPT	DESCRIPTION
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rprt
0379T	Vis field assmnt tech suppt
0419T	Dstrj Neurofibroma Xtnsv
0420T	Dstrj Neurofibroma Xtnsv
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0529T	Interrog dev eval iims ip
0530T	Removal complete iims
0551T	Tprnl balo cntnc dev adjmt
0563T	Evac Meibomian gld heat bilat
0566T	Auto cell implt adps tiss njx imp knee
0588T	Rev or rem isdns post tibial nrv
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Instructions for Completing a UB 04 Form

Form Locator	Instructions
FL01	**Billing Provider Name, Street Address and Telephone Number** Enter the billing provider's name, city, state, and nine-digit ZIP Code
FL02	**Billing Provider's Designated Pay to Name** Not applicable
FL03a	**Patient Control Number** Enter the patient's unique alpha-numeric control number assigned by the provider to facilitate retrieval of individual financial records and posting payment may be shown if the provider assigns one and needs it for association and reference purposes.
FL03b	**Medical/Health Record Number** Enter the number assigned to the patient's medical/health record by the provider
FL04	**Type of Bill** Enter the four-digit alphanumeric code. The 4th digit indicates the sequence of the bill in the episode of care and is referred to as a "frequency" code. If the 4th digit is billed as 0 (zero), the claim is defined as a "Nonpayment/Zero Claims" and will not be considered for payment.
FL05	**Federal Tax ID** Enter the Tax ID Number
FL06	**Statement Covers Period – From/Through** Enter the beginning and ending dates of the period included on the bill in numeric fields (MMDDYY)
FL07	**Reserved for Assignment by NUBC** Not applicable
FL08	**Patient Name** Enter the patient's last name, first name, and, if any, middle initial, along with patient identifier (if different than the subscriber/insured's identifier). **Name on Baby's Claim** When submitting a separate claim for a level two, three or four NICU newborn, enter the baby's name rather than "baby boy" or "baby girl." In the case of twins, indicate the baby's name rather than "Baby A" or "Baby B." Blue Shield will return the unprocessed claim if the baby's name is missing.

FL09 **Patient Address**

Enter the patient's full mailing address, including street number and name, post office box number or RFD, city, State, and ZIP Code.

FL10 **Patient Date of Birth**

Enters the patient's date of birth.

FL11 **Patient Sex**

Enter the sex of the patient.

FL12 **Admission/Start of Care Date**

Enter the date the patient was admitted for inpatient care (MMDDYY). The HHA enters the same date of admission that was submitted on the RAP for the episode.

FL13 **Admission Hour**

Enter the two-digit military time code to indicate the admission hour.

FL14 **Type of Admission**

Enter the Type of Admission

FL15 **Source of Referral for Admission or Visit**

Enter the source using the one-digit code that represents the source of referral for admission.

Maternity Claims – Charges for the mother and ***level one NICU*** baby should be billed together, either on the same claim or at the same time. However, if the baby requires placement in a level two, three, or four Neonatal Intensive Care Unit (NICU) room (Revenue Code 172, 173, or 174, respectively), separate claims should be submitted for the mother and baby**.**

Note: For network hospitals with negotiated per diem/case rates, only one per diem/case rate will be paid for both the mother and baby, except when the baby requires placement in level two, three or four NICU or if the baby is in a level one NICU after the mother's discharge.

FL16 **Discharge Hour**

Enter the two-digit military time code to indicate the discharge hour.

FL17 **Patient Discharge Status**

Enter the two-digit status of the patient when service is ended.

FL18 – FL28 **Condition Codes**

Enter the corresponding code in numerical order to describe any conditions or events that applied to the billing period.

FL29 **Accident State**

Not applicable

FL30 **Reserved for Assignment by NUBC**

Not applicable

FL31 – FL34 **Occurrence Code/Date**

Enter occurrence code and associated dates defining specific events relating to the billing period.

FL35 – FL36 **Occurrence Span Code/From/Through**

Enter codes and associated beginning and ending dates defining a specific event relating to this billing period. Event codes are two alpha-numeric digits and dates are shown numerically as MMDDYY.

FL37 **NOT USED**

Not applicable

FL38 **Responsible Party Name/Address**

Not applicable

FL39 – FL41 **Value Code and Value Code Amount**

Enter the appropriate value code(s) and corresponding amount(s).

FL42 **Revenue Codes**

Enter valid Revenue Code for the services provided. Blue Shield will deny charges billed with invalid Revenue Codes.

Note: Certain billing scenarios may require Blue Shield to apply billed charges to Revenue Code 249. In some billing scenarios, Blue Shield may add Revenue Code 249 to identify combined or non-payable charges.

FL43 **Revenue Code Description**

Enter a narrative description or standard abbreviation for each revenue code category.

FL44 **HCPCS/Accommodation Rates/HIPPS Rate Codes**

Enter valid HCPCS and appropriate modifier, rate or HIPPS Code for the services provided. Blue Shield encourages the use of modifiers in accordance with the National Uniform Billing Committee and the *California UB 04 Billing Procedures Manual*, as modifiers more accurately define the service(s) provided.

UB-04 General Instructions

FL45 **Service Dates**

When billing for outpatient services and the "Statement Covers Period" (Form Locator 6) spans multiple dates, each service must be entered on a separate line with the actual date of service performed.

Multiple room and board individual dates of service are needed to process inpatient claims within Form Locator 45 or on the itemization.

Note: For network hospitals with negotiated per diems, additional payment for late discharges cannot be made under the terms of your contract.

Outpatient Charges and Multiple Inpatient Room & Board Charges must identify the date on each service line.

FL46 **Service Units**

Enter the number of units, days, or visit where appropriate

FL47 **Total Charge**

Enter the total charges for the number of charges billed.

FL48 **Non-Covered Charges**

Enter the total non-covered charges pertaining to the related revenue code in FL42.

FL49 **Reserved for Assignment by NUBC**

Not applicable

FL50-55 **Other Payor Information**

Enter the appropriate information if applicable as follows:

Box 50a-c: **Payor Name** – Enter the Primary payor name. Secondary/Tertiary information can be entered on the lines below.

Box 51a-c: Health Plan ID – Enter the Health Plan ID

Box 52a-c: **Release of Information** – Each payor line will have a separate Release of Information Certification Marker Box.

Box 53a-c: **Assignment of Benefits** – Each Payor line will have a separate Assignment of Benefits Marker Box.

Box 54a-c: **Prior Payments** – Enter any prior payment amounts received toward payment of the bill for the payor indicated in box 50.

Box 55a-c: **Estimated Amount Due** – Enter estimated amount due from each indicated payor in box 50.

FL56 **Billing Provider National Provider ID (NPI)**

Enter the National Provider ID for the billing provider.

FL57 **Other Provider ID**

Enter the Blue Shield Provider Identification Number (PIN).

FL58-65 **Insured's Information**

Box 58a-c: **Insured Name** – Enter the name of the policyholder for the primary/secondary/tertiary health plan as indicated in Box 50a-c

Box 59a-c: **Patient Relationship** – Identify the relationship of the patient to the primary insurance policyholder.

Box 60a-c: **Insured ID Number** – Enter the ID number for the Insured.

Box 61a-c: **Group Name** – Enter the Group Name of the Insured.

Box 62a-c: **Insured Group Number** – Enter the Group Number of the Insured.

Box 63a-c: Treatment Auth Codes – Enter the authorization or referral number assigned by the payor.

Enter the reference number that Blue Shield issues to track pre-admission information. For Access+ HMO and POS patients, enter both the Blue Shield tracking number and the reference number provided by the patient's IPA/medical group, if applicable. For emergency room visits, enter the name or license number of the authorizing physician, if the patient's primary care physician referred or approved the admission.

Box 64a-c: Document Control Number – Enter the Document Control Number assigned by the health plan

Box 65a-c: Employer Name – Not applicable

When more than one insurance carrier is involved, enter complete information regarding the primary, secondary, and other carriers and members. Indicate the other insurance carrier's name, address, and policy number in the "Remarks" section. Also include any payment information, if known. When Blue Shield is the secondary payor, attach a copy of the primary carrier's remittance advice or EOB. Also attach a copy of the other insurer's identification card, if available.

- If other insurance is indicated:
    - Line A – Enter the Primary Carrier information.
    - Line B - Enter the Secondary Carrier information.
    - Line C - Enter the Tertiary information.
    - COB claims can be received electronically up to Tertiary. Blue Shield follows CMS guidelines. For facility inpatient claims, the COB is submitted at the claim level. For facility outpatient and professional claims, the COB is provided at the line level adjudication. For specific guidelines refer to Blue Shield's 837 Companion Guide found on Provider Connection at blueshieldca.com/provider.

FL66 Diagnosis and Procedure Code Qualifier

Enter the Primary diagnosis code and the qualifier code 0 for the tenth revision (ICD-10-CM)

FL67a – FL67q Other Diagnosis and POA Indicator

Enter all the diagnosis codes corresponding to all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. Enter all the diagnosis codes using current ICD-10-CM Manual for accurate coding. The Present on Admission (POA) indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *ICD-10-CM Official Guidelines for Coding & Reporting*) on all inpatient acute care facility claims.

FL68 Reserved for Assignment by NUBC

Not applicable

FL69 Admitting Diagnosis

For inpatient hospital claims, the admitting diagnosis is required. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.

FL70a – FL70c Patient Reason for Visit Code

Enter the complete ICD-10-CM code describing the patient's reason for visit at the time of registration.

FL71 Prospective Payment System Code

Enter the appropriate DRG code

FL72a-c External Cause of Injury Codes and POA Indicator

Inpatient acute care facility claims must contain the External Cause of Injury (ECI) ICD-10-CM Code, along with the POA indicator, when an injury, poisoning, or adverse effect occurs during the medical treatment.

FL73 Reserved for Assignment by NUBC

Not applicable

FL74 Principal Procedure Code and Date

Enter the procedure code and date when a procedure was performed. Not used on outpatient claims.

FL74a – FL74e Other Procedure Codes and Dates

Enter the procedure code and date when additional procedure was performed. Not used on outpatient claims

FL75 Reserved for Assignment by NUBC

Not applicable

FL76 **Attending Provider Name and Identifiers (including NPI)**

Enter the name and NPI of the attending physician.

FL77 **Operating Provider Name and Identifiers (including NPI)**

Enter the name and NPI of the individual with the primary responsibility for performing the surgical procedures.

FL78 – FL79 **Other Provider Name and Identifiers (including NPI)**

Enter the name and NPI of the provider that corresponds to the indicated provider type on the claim.

FL80 **Remarks**

Can be used to put free text for remarks or comments.

FL81 **Code-Code Field**

Enter the taxonomy code.

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Reimbursement for Implants

Reimbursement for implants is based on a facility's contractual agreement in effect at the time services are rendered.

Blue Shield reimburses facilities for implants provided to Blue Shield members using a variety of payment terms, some of which include the cost of the implant.

For agreements under which implants are reimbursed on a cost basis with an administrative fee, the reimbursement is calculated as follows:

Reimbursement = Cost Implants +

((Cost of Implants/total invoice amount, exclusive of tax, shipping and handling costs) x (total tax + shipping + handling costs)) +$25

Example:

Invoice:	
Implants:	$ 3,000
Other items:	$10,000
Total invoiced tax:	$ 1,064
Total invoiced shipping and handling:	$ 300
Total invoice amount:	$14,364

Implant reimbursement = $3,000 + (($3,000/$13,000) x (300 + $1,064)) + $25 = $3,339.77

Reimbursement for Implants

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