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If you have questions about electronic claim submission, please call the Electronic Data Interchange (EDI) Help Desk at (800) 480-1221. You may also visit Provider Connection at blueshieldca.com/provider and click on the *Claims* section under *Enroll in Electronic Data Interchange*.

Special Guidelines for the CMS 1500 Claim Form

The following instructions apply to the related “field” of the electronic claim record. Refer to Appendix 4-D for comprehensive instructions for completing the CMS 1500 claim form.

Block 1 - 8 – Patient Information

la. Insured's ID number.

Consult the system documentation provided by your software vendor to ensure your system can accept and transmit the three-letter alpha-numeric prefix in your electronic claims submissions.

Blocks 9 - 9d – If Blue Shield is the Secondary Payor

Blue Shield can accept claims electronically when Blue Shield is the secondary payor. Consult your software documentation or vendor to determine if your software package can support submitting secondary insurance claims.

Block 10a - 10c – Patient Condition

Auto or Other Accident (injury) indicator must contain the correct field value in order for Blue Shield to correctly move the Date of Injury from the electronic claim record onto our claims processing system. Consult your software vendor, billing service or clearinghouse to verify they have correctly identified the value for the electronic claim.

Block 14 – Date of Current Illness, Injury or Pregnancy

Date of illness, injury or pregnancy is always a required field on your electronic claim record. However, Blue Shield will move the date information from the electronic record to our claims processing system only if the value(s) in Block l0b or 10c indicate the equivalent of "Y" to Auto or Other Accident. If you are experiencing problems in which Blue Shield is requesting the date of injury on your electronic claim, check with your software vendor, billing service or clearinghouse to verify that they correctly identified these values.

Block 17 – 17b - Referring or Ordering Physician

17. Name of Referring or Ordering Physician or Other Source

Electronic claim record of Referring Physician:

- Last Name Field (Claim Header Record) -Enter "Self-referral"
- First Name Field (Claim Header Record) -Leave Blank

Guidelines for Successful OCR Processing

Follow the guidelines below to assure successful Optical Character Recognition (OCR) entry of CMS 1500 paper claims.

- Use only original CMS 1500 claim forms printed in "red dropout" ink. The ink used to print the form must not contain any carbon.
- Use the same font and the same entry method on the entire form. Use Pica, Arial 10, 11, or 12 font type; black ink; and input data in CAPITAL letters. Mixing entry methods (e.g., adding typewritten information to a claim already printed on a laser printer) may impede processing.
- Left justify information in each box and keep data from touching box edges or running outside of numbered boxes.
- Keep claims clean, free of smudges or discolored erasure marks. You may use white correction tape but not correction liquids because OCR can read through them. If you use correction tape, be certain any printing on it is blemish-free.
- The service area of the claim form (Blocks 24a-24j) must be no more than six lines per claim. If you need to submit more than six lines of services for one patient, use separate forms.
- Note: Enter "continued" in the Total Charges field on the first claim to ensure it is processed as a single claim.
- Use the proper units of service in Block 24g. If units are not used, the claim may default to 1 unit during processing, or the claim may be returned to you for more information.
- Enter appropriate ICD-10 codes in the diagnosis (Block 21) or the CPT and Modifier codes in service line (Blocks 24a-24j) areas. Comments or narrative descriptions of procedures, modifiers, or diagnosis codes will require claims to be manually entered into our processing system.
- Attachments cannot be read via OCR but will be reviewed by a claim's specialist. To ensure attachments can be read and understood, they must be 8.5 by 11 inches and should be produced in clean, readable printing in dark ink, preferably on white paper.

Additional Claims Submission Pointers

To expedite the processing of your claims, here are some additional claims submission pointers:

- When billing for drugs, supplies and equipment, use HCPCS codes. Drug codes also require the National Drug Code (NDC) be submitted.
- Use the most current ICD-10-CM for coding all diagnoses, including mental disorders.
- Identify diagnoses as precisely as possible. To expedite claim processing, always use four-digit codes, unless there is none in the particular coding category, and add a fifth digit sub-classification code whenever one exists.
- To ensure proper eligibility, obtain a copy of the Subscriber's Blue Shield ID card to verify the correct subscriber's name, number, and employer group information. You may visit Provider Connection at blueshieldca.com/provider for up-to-date eligibility verification.
- For correct benefit consideration, report same-day services for the same patient on the same claim. If services exceed more than six detail lines, use separate forms. In order to ensure that multiple forms are processed as a single claim, enter "continued" or "Page 1 of 2" in the Total Charges field.

  Blue Shield's processing system allows up to a maximum of 20 detail lines per electronic professional claims.
- Hospitals must submit professional services by professional electronic claim format or on a CMS 1500 claim form. You may no longer bill these services under revenue codes using the hospital's facility NPI on a UB 04 (or successor) claim form. All Blue Shield hospitals must establish a professional NPI to bill for these services.

Additional Claims Submission Pointers *(cont'd.)*

- Claims for ancillary services (clinical lab, specialty pharmacy and DME/HME) may require additional location information in order to determine the local plan.

  For EDI claims:

  - Loop 2310 837P Referring Provider segment with the NPI in the NM109
  - Loop 2420E 837P Ordering Provider Segments with the NPI in the NM109 including the N3 and N4 address segments if applicable

  For CMS 1500:

  - Block 5 Enter patient's complete current address and telephone number.
  - Block 17-17a Enter name and NPI of the referring physician.

    Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words "self-referral."

  - Block 24b For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
  - Block 32 – 32a For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.

Blue Shield may require additional documentation to complete the processing of a claim. The documentation should be complete and legible. Types of documentation may include but are not limited to:

1. Operative Reports
2. Emergency Room Reports
3. Consultant Reports
4. Test Records
5. Facility Records
6. NIA Authorization

On claims for which you normally include more detailed information on the claim line, please contact the EDI Help Desk at (800) 480-1221 to confirm where this information would go in the electronic format.

Ambulance Claims

Ambulance claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Include the additional coding requirements from the ambulance claim guidelines below so claims can be processed accurately. For more information, complete EDI Companion Guides are available on Provider Connection at blueshieldca.com/provider in the *Claims* section. Call the EDI Help Desk at (800) 480-1221 with any questions.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
170	2300	CLM	Claim Information		
172	2300	CLM05	Health Care Service Location Indicator (Place of Service)	41 - land 42 - water	Use for 'type of transport.'
227	2300	REF	Prior Authorization or Referral Number		
227	2300	REF01	Reference Identification Qualifier	G1	Prior authorization qualifier
	2300	REF02	Prior Authorization or Referral Number		911 plus any free form comments/ information up to 26 characters
246	2300	NTE02	Description		Report location to which patient was transported. Include facility name, city, and zip code.
247	2300	NTE01	Note Reference Code	ADD	Use in conjunction with NTE02 to identify the purpose of the notes in NTE02
248	2300	CR	Ambulance Transport Information		
249	2300	CR103	Ambulance Transport Code	I, R, T, X	Use for 'transport information.' All values are accepted.
250	2300	CR106	Quantity		Use to report transport distance.
250	2300	CR109	Description		Free format field. Use to clarify the purpose for the round-trip service.
250	2300	CR110	Description		Free format field. Use to clarify details regarding use of a stretcher during service.
303	2310D	NM1	Service facility location		
304	2310D	NM101	Entity identifier code	77	Service location. Qualifies patient pick-up location.
304	2310D	NM102	Entity Type qualifier	2	Non-person entity qualifier

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
304	2310D	NM103	Organization name		Name of location where patient was picked-up, e.g., RESIDENCE (up to 35 characters).
307	2310D	N3	Service facility location address		
307	2310D	N301	Address Information		Address of location where patient was picked up
308	2310D	N4	Service facility location city/state/zip code		
308	2310D	N401	City		City in which patient was picked up
309	2310D	N402	State		State in which patient was picked up
309	2310D	N403	Zip Code		Zip code of location where patient was picked up
400	2400	SV1	Professional Service		
404	2400	SV105	Place of Service		Line level place of service value
412	2400	CR1	Ambulance Transport Information		
412	2400	CR1	Ambulance Certification		Line level ambulance information (see page 248-Loop 2300 CR103, CR104, CR106, CR109, and CR110).
488	2400	NTE	Line Note		
488	2400	NTE01	Note Reference Code	ADD	Use in conjunction with NTE02 to identify the purpose of the notes in NTE02.
488	2400	NTE02			Free format field. Use for any additional comments.

Drug Requirements - 837 Professional Claims

Home infusion services and office administered drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

For billing purposes, drugs must be submitted with a HCPCS code and NDC. NDCs contain 11 digits in a fixed 5-4-2 configuration. The NDC found on the outer package must be submitted. DO NOT submit NDC found on individual vials or doses. If the NDC on a product does not contain 11 digits, leading zeros should be added to fill in the missing number(s) to maintain the 5-4-2 format.

Example for billing purposes when the NDC has less than 11 digits should be used:

- NDC On Product: 345-1234-2 (NDC has only 8 digits, but 11 digits are required)
- NDC For Billing: **00**345-1234-02 (Leading zeros are added to conform with the 5-4-2 configuration)

Please use the following guidelines:

- Report the appropriate HCPCS code in the service line of the claim (loop 2400 SV101-1).
- Report date of service in the service line (loop 2400 DTP03).
- Report name of drug in service line notes (loop 2400 NTE-2).
- Use qualifier "N4" for NDC format 5-4-2 (loop 2410 LIN02).
- Report the National Drug Code (Loop 2410 LIN03).
- If the price of the NDC drug reported in LIN03 is different from the charges reported in the SV102, create a CTP segment in loop 2410.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
400	2400	SV101-1	Product/Service ID qualifier	HC	
400	2400	SV101-2	Product/Service ID	HCPCS	J or Q codes for home, office infusion/drugs
435	2400	DTP01	Service line date qualifier	472	Service line date of service
	2400	DTP03	Date time period	DATE	Date, a time, range of dates
472	2400	REF02	Line Item control number	Provider control number	Providers submit these to assist posting the 835 sent back.
488	2400	NTE01	Note reference code	"ADD"	Only "ADD" is acceptable for these claims.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
488	2400	NTE02	Description		Name of drug and any pertinent information – up to 80 bytes
AD 73	2410	LIN02	Product/Service ID qualifier	"N4"	National drug format 5-4-2
AD 74	2410	LIN03	Product/Service ID		National drug code
AD 75	2410	CTP03	Drug unit price		Required only if price is different from how it appears in the SV102. Price per unit of product, service, commodity, etc.
AD 75	2410	CTP04	Quantity		National drug unit count
AD 75	2410	CTP05	Composite unit of measure		Unit or basis of measurement
AD 75	2410	CTP05-1	Unit or basis of measurement code	F2-International Unit GR-Gram ML-Milliliter UN-Unit	Include the appropriate qualifier.
AD 77	2410	REF02	Pharmacy prescription number		Required if the drug has been dispensed with an assigned RX number.

Genetic and Molecular Testing – 837 Professional Claims

A procedure description is required for Unlisted Genetic and Molecular Testing procedure codes with use of the Genetic Testing Unit (GTU). The specific GTU for each procedure code can be identified by accessing Concert Genetics Provider Portal at www.concertgenetics.com/join-blue-shield-california. Providers are required to bill according to the CPT coding established in the Concert Genetics portal.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
	2400	SV101-7	Genetic Testing Unit		Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G

Nurse Practitioner and Physician Assistant

Claims submitted for these services should include the Name and NPI of the Nurse Practitioner or Physician Assistant as the rendering provider (Loop 2310 B) and the Supervising Physician Name and NPI referenced in the 2310D Loop.

837 Institutional Claims

Home infusion services and drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

- Report name of the drug in the claim note (loop 2300 NTE02 – note: use "MED" in NTE01).
- Report description using up to 80 bytes, placed in order of the service lines (see example below).
- Report HCPCS code of drug at the service line (loop 2400 SV202-2 (use "HC" in SV202-1).
- Report date of service in the service line (loop 2400 DTP03). Use "472" in DTP01.
- Use qualifier "N4" for NDC format 5-4-2 (loop 2410 LIN02).
- Report the national drug code (loop 2410 LIN03).
- If the price of the NDC drug reported in LIN03 is different from the charges reported in the SV203, create a CTP segment in loop 2410.
- Refer institutional addenda for reference (pages 38-39).
- Report the quantity of drug dispensed (loop 20140 CTP04).
- Report the appropriate drug unit quantity qualifier (loop 2010 CT05-1).

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
207	2300	NTE01	Note reference code	"MED"	Medications
207	2300	NTE02	Description		Name of drugs. Use up to 80 bytes and show in order of service lines. Following is an example: (NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).
446	2400	SV202-1	Product/Service ID qualifier	"HC"	HCPCS code qualifier
447	2400	SV202-2	Product/service		Service code
456	2400	DTP01	Service line date qualifier	"472"	Service line date of service
456	2400	DTP03	Date time period		Date, a time, or range of dates
AD37	2410	LIN02	Product/service ID qualifier	"N4"	National drug format 5-4-2
AD38	2410	CTP03	Unit price		Required only if the price is different from how it appears in SV102. Price per unit of product, service, commodity, etc.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
AD38	2410	CP04	Quantity		National drug unit count
AD38	2410	CTP05	Composite unit of measure		Unit or basis of measurement
AD38	2410	CTP05-1	Unit or basis of measurement code	F2-Int'l Unit GR-Gram ML-Milliliter UN-Unit	Include the appropriate qualifier.
AD77	2410	REF02	Pharmacy prescription number		Required if the drug has been dispensed with an assigned RX number

HEDIS® Guidelines

Each HEDIS measure identified below has criteria that is required for your patient's chart or claims review to be considered valid towards HEDIS measurement. In addition to using CPT/HCPCS codes, please use CPT Category II codes to help your office to meet criteria for HEDIS measures:

Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests Most recent hemoglobin A1c level <7.0%c	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level greater than 9.0%	3046F
LDL-C Tests Most recent LDL-C < 100 mg/dL	3048F
LDL-C Tests Most recent LDL-C 100 - 129 mg/dL	3049F
LDL-C Tests Most recent LDL-C ≥ to 130 mg/dL	3050F

Comprehensive Diabetes Care	
Test or Biometric Value	**CPT Category II Code**
Diabetic Retinal Screening Negative *Low risk for retinopathy (no evidence of retinopathy in the prior year)*	3072F
Diabetic Retinal Screening With Eye Care Professional Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2022F
Diabetic Retinal Screening With Eye Care Professional Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2023F
Diabetic Retinal Screening With Eye Care Professional 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2024F
Diabetic Retinal Screening With Eye Care Professional 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2025F

Diabetic Retinal Screening With Eye Care Professional Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy	2026F
Diabetic Retinal Screening With Eye Care Professional Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	2033F
Diastolic Most recent diastolic blood pressure < 80 mm Hg	3078F
Diastolic Most recent diastolic blood pressure 80 – 89 mm Hg	3079F
Diastolic Most recent diastolic blood pressure ≥ 90 mm Hg	3080F
HbA1c Tests Most recent hemoglobin A1c level <7.0%Diastolic Less Than	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level > 9.0%	3046F
Systolic Most recent systolic blood pressure < 130 mm Hg	3074F
Systolic Most recent systolic blood pressure 130 to 139 mm Hg	3075F
Systolic Most recent systolic blood pressure < 140 mm Hg	3076F
Systolic Most recent systolic blood pressure ≥ 140 mm Hg	3077F

Care for Older Adults	
Test or Biometric Value	**CPT Category II Code**
Advance care plan or similar legal document present in the medical record	1157F
Advance care planning discussion documented in the medical record	1158F
Functional status assessed	1170F
Medication list documented in medical record	1159F
Medication Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record	1160F
Pain Assessment Pain severity quantified; pain present	1125F
Pain Assessment Pain severity quantified; no pain present	1126F

Frequency of Ongoing Prenatal Care	
Test or Biometric Value	**CPT Category II Code**
Stand Alone Prenatal Visits: Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP])	0500F
Stand Alone Prenatal Visits: Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	0501F
Stand Alone Prenatal Visits Subsequent prenatal care visit	0502F

Medication Reconciliation Post-Discharge	
Test or Biometric Value	**CPT Category II Code**
Medication Reconciliation Discharge medications reconciled with the current medication list in outpatient medical record	1111F
Postpartum Care Visit	0503F

Prenatal and Postpartum Care	
Test or Biometric Value	**CPT Category II Code**
Stand Alone Prenatal Visits: Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP])	0500F
Stand Alone Prenatal Visits: Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	0501F
Stand Alone Prenatal Visits Subsequent prenatal care visit	0502F

Cardiovascular Monitoring for People With Cardiovascular Disease	
Test or Biometric Value	**CPT Category II Code**
LDL-C Tests Most recent LDL-C < 100 mg/dL	3048F
LDL-C Tests Most recent LDL-C 100 - 129 mg/dL	3049F
LDL-C Tests Most recent LDL-C ≥ to 130 mg/dL	3050F

Diabetes Monitoring for People With Diabetes and Schizophrenia	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests Most recent hemoglobin A1c level <7.0%	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level > 9.0%	3046F
LDL-C Tests Most recent LDL-C < 100 mg/dL	3048F
LDL-C Tests Most recent LDL-C 100 - 129 mg/dL	3049F
LDL-C Tests Most recent LDL-C ≥ to 130 mg/dL	3050F

Diabetes Screening for People With Schizophrenia or Bipolar Disorder	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests Most recent hemoglobin A1c level <7.0%	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level > 9.0%	3046F

Submitting Claims/Encounters Electronically and Electronic Payments

Blue Shield's Electronic Data Interchange (EDI) program enables the paperless exchange of information between Blue Shield, providers, and other business partners. All EDI transactions follow HIPAA-compliant guidelines for format and code. Improved cash flow through quicker receipt of claims, improved efficiencies through less paperwork, and enhanced accuracy of data are just a few of the benefits EDI offers.

Electronic Claim Submission – Providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Electronic Funds Transfer (EFT) – Providers are required to receive claims payments electronically through direct deposit of funds into a designated bank account based on information submitted by the provider.

Electronic Remittance Advice (ERA) – Providers are required to receive ERA files or view Explanation of Payment (EOP) using Blue Shield's Provider Connection website at blueshieldca.com/provider.

Electronically transmitted claims and payments are more secure, efficient, and cost-effective than paper remittance; they help to reduce revenue cycle times and are environmentally friendly. Providers are required to have an internet connection for all electronic transactions.

EDI Claims (837)

- Reduce your accounts receivable days outstanding. EDI claims arrive the same day the data is transmitted and 99.1 percent process in less than 6 days
- Reduce errors and rebilling; more than 85 percent of EDI claims accepted require no human intervention to adjudicate
- Save money when you eliminate paper, postage, and handling costs
- Tighten your revenue management using the quick-response alerts you'll receive on rejected EDI claims

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.

To enroll in electronic claim submission, providers can us any approved clearinghouse listed on Provider Connection. Provider can submit claim 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 Help Desk at (800) 480-1221.

Submitting Claims/Encounters Electronically and Electronic Payments *(cont'd.)*

EDI Claims Status Inquiries (276)

Providers use the EDI Claim Status Inquiry transaction (EDI 276) to inquire about the status of a claim after it has been submitted to Blue Shield. The claim status response transaction (EDI 277) is then returned in response to a request inquiry about the status of a claim. The claim status response (EDI 277) indicates if a claim is pending or finalized. If finalized, it states the disposition of the claim – rejected, denied, approved for payment, or paid.

If the claim was approved or paid, payment date, amount, etc. may also be provided in the 277. If the claim was denied or rejected, the 277 includes an explanation, such as if the subscriber is not eligible.

Benefits of using EDI Claim Inquiry are:

- Increase efficiency by tracking claims in seconds eliminating unnecessary claims tracing
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce accounts receivable days outstanding by receiving responses the next business day

To enroll for the EDI Claim Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in EDI,* contact the EDI Help Desk at (800) 480-1221.

Improve Security of PHI and Financial Information

EDI Eligibility Inquiries (270/271)

The EDI Eligibility and Benefit inquiry (EDI 270/271) is used to verify information about the healthcare eligibility and benefits associated with a subscriber or dependent. The eligibility and benefit response (EDI 271):

- Checks member eligibility and benefits within seconds
- Provides correct member demographic information
- Verifies member liability and accumulated amounts including copays, deductibles, and out-of-pocket expenses
- Confirms member coordination of benefits (COB) information

Advantages of checking member eligibility and benefits are:

- Fewer rejected claims

Improve Security of PHI and Financial Information *(cont'd.)*

- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce collection and billing costs

To enroll for the EDI Eligibility Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Manage electronic transactions* or contact the EDI Help Desk at (800) 480-1221.

EDI Authorizations (278)

Blue Shield offers health care providers the ability to submit request for prior authorization, (e.g., preapproval, preauthorization, prior notification, etc.) review, and receive responses electronically.

This allows the provider to:

- Track records more easily when you receive documentation of authorization requests
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce the potential for patient care delays associated with prior authorization

To enroll for EDI Authorizations, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in EDI* or contact the EDI Help Desk at (800) 480-1221.

Electronic Remittance Advice (ERA) 835

- Save administrative costs – automate the payment posting process
- Reconcile transactions more quickly
- Reduce payment posting errors
- Reduce paper handling and storage costs
- Convert paper remittance to a single electronic format for your account receivable system

ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format. The ERA replaces the paper Explanation of Payment (EOP). To enroll for the ERA, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in EDI* or by contacting the EDI Help Desk at (800) 480-1221.

Improve Security of PHI and Financial Information *(cont'd.)*

Electronic Funds Transfer (EFT)

- Get administrative time and cost with direct deposits into specified accounts faster payment and reduce
- Increase security of payments – eliminate lost checks
- Get more accurate banking audit results – consult with your financial institution regarding available options

EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. Providers are required to receive claims payments electronically. The EFT process is set up to ensure privacy in addition to being quick and efficient. To enroll for EFT, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in EDI,* contact the EDI Help Desk at (800) 480-1221.

Methods for Direct Transmission of HIPAA-Compliant Transactions

Secure File Transfer Protocol (SFTP)

- Use it for all HIPAA transactions, claims/encounters, ERA, eligibility, claim status, authorizations
- Receive a detailed report the same or next business day
- Support unattended scripted file transfers
- Use robust data exchange capability for larger file size and faster data transfer

Real-time HTTP/s Connectivity

Blue Shield supports CORE Phase II HTTP/s open connectivity standards, HTTP MIME Multipart and SOAP+WSDL for EDI eligibility and claim inquiries.

Blue Shield, in accordance with HIPAA regulation, accepts electronic claims submitted in the ANSI format version 5010. The "Special Billing Guidelines and Procedures" instructions in Appendix 4 apply to both the identified "block" on the CMS 1500 and the related "field" on the electronic record, unless otherwise indicated. Your electronic claims software may have additional specific requirements. Follow the system documentation provided by your software vendor.

The creation of the National Provider Identifier (NPI) was mandated by HIPAA and is an attempt to ensure that all medical providers can be identified by a single identifier across all payor systems. To implement the NPI, Blue Shield cross-references the NPI to the correct provider records in our system. On the CMS 1500 Form, the National Provider Identifier would be noted in Box 33A. Providers should have applied for and received their type 1 and/or type 2 National Provider Identifier through the CMS NPPES website and be submitting that information on all claims. The NPI should also be registered with Blue Shield prior to submitting claims.

Special Billing Situations

Ambulance

Providers are required to submit ambulance claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. By using the coding requirements for the ANSI format, you have the ability to provide Blue Shield with the required information normally obtained from trip notes and additional reports. Within the electronic format you will need to provide the information specific to emergency transports by using a variety of the fields available, including the notes section using the 2300 loop within the REF02 segment. The detailed billing requirements are available on Provider Connection.

Providers needing to schedule ambulance services should go to Provider Connection at blueshieldca.com/provider and click on *Guidelines & resources*, *Patient care resources*, then *Ancillary Provider Rosters* to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.

Special Billing Situations *(cont'd.)*

Ancillary Claims Filing Requirements

Submit ancillary claims electronically using instructions below. The referring/ordering physician is required to identify the local plan.

- Loop 2310 837P = Referring Provider segment with the NPI in the NM109.
- Loop 2420E 837P = Ordering Provider Segments with the NPI in the NM109 including the N3 and N4 address segments, if applicable.

Submit Self-Referred Claims Electronically

When Point of Service (POS) plan members self-refer to a specialist, use the instructions below to bill electronically. For questions, contact your clearinghouse or billing system vendor, contact the EDI Help Desk at (800) 480-1221.

Submitting Self-Referral for POS Professional & Institutional Claims

- Self-Referral for Professional is identified in Loop 2310A
- Self-Referral for Institutional is identified in Loop 2310F
- Insert SELRREFERRAL for NM103 but leave blank NM104
- Use generic NPI for NM109

  Sample: SELFREFERRAL

  NM1*DN*1*SELFREFERRAL*****XX*1002233777~

Special Billing Situations *(cont'd.)*

Reporting NDC Codes on X12N EDI

Professional and Institutional Claims and Encounters

Home Infusion Professional Claims

Home infusion services and drug claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Use the following guidelines:

- Report name of the drug in the claim note (Loop 2300 NTE02). Use "MED" in NTE01.
- Report description using up to 80 bytes, placed in order of the service lines (See example below).
- Report HCPCS code of drug at the service line (Loop 2400 SV202-2). Use "HC" in SV202-1.
- Report date of service in the service line (Loop 2400 DTP03). Use "472" in DTP01.
- Use qualifier "N4" for NDC format 5-4-2 (Loop 2410 LIN02).
- Report the national drug code (Loop 2410 LIN03).

Notes:

207 2300 NTE01 Note reference - "MED" is Medications.

207 2300 NTE02 Description - Name of drugs. Use up to 80 bytes, and show in order of service lines.

Example:

(NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).

A new field is available in 5010 for description of services that can be used for drug specifics or any additional information needed for the claim. The NTE segment can also still be utilized.

Examples:

Professional Claim / SV102-7

SV1*HC>J3490>>>>>MULTITRACE-4 10ml Conc.*11.94*UN*1.000***1~

Special Billing Situations *(cont'd.)*

Submit Prior Authorization Numbers Electronically

For both Institutional and Professional EDI claims, report Prior Authorization Number in the REF02 segment in Loop 2300. Use the "G1" qualifier in the REF01 segment of Loop 2300.

REF01 = G1

REF02 = Authorization Number

Sample: REF*G1*12456789ABCD

Report the entity that approved the authorization (Blue Shield, IPA, NIA), authorization date, date range service approved, and approved days/units in NTE02 Loop 2300. For Professional claims, use the "Claim Note" and for Institutional claims, use the "Billing Note." In both Professional and Institutional claims, use "ADD" as the value in NTE01.

Sample: NTE*ADD* BSC 20050719 20050719 20050722 4 DAYS

- The first field is either BSC, IPA, or NIA
- The second field is the date the authorization was given (use ccyymmdd format)
- The third field is the date range approved (use ccyymmdd format)
- The fourth field is either the amount of days approved or units

For additional information or specifics on billing claims electronically for secondary and tertiary insurance, drugs, or home infusion, please contact the EDI Help Desk at (800) 480-1221.

Special Billing Situations *(cont'd.)*

Submit Corrected Claims Electronically

Corrected claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please wait for the original claim to finalize before sending a corrected claim to avoid denial as a duplicate.

Once the initial has finalized in our system, re-submit the corrected claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on your adjusted claim:

- Send "F8" in REF01 (Loop 2300)
- Send 12-digit number BSC Payer Claim Control Number of incorrect original claim in REF02 (Loop 2300)
- Sample: REF*F8*12345678912345~

Note: 12345678912345 should be replaced with the original claim's Blue Shield of California internal control number (ICN).

You can obtain the Blue Shield claim number using the claim status option on Provider Connection or from the explanation of benefits (EOB) or electronic remittance advice (ERA).

Additional Reports

For providers that are submitting to Blue Shield in the ANSI 5010 format they will also receive reports that are specific to the 837 claims transaction.

Interchange Acknowledgment – TA1 – Provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Functional Acknowledgment – 999 – Identifies the acceptance or rejection of the functional group, transaction sets or segments.

Unsolicited Claim Status Information Report 277CA v 5010 – Blue Shield validates inbound electronic data interchange (EDI) for HIPAA compliance, advising only of HIPAA level rejections.

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Instructions for Completing a CMS 1500 Form

See a sample of the CMS 1500 Claim Form and additional information on Provider Connection at https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/claims/policies_guidelines/claim_forms_guidelines.

Block #	Instructions
1	**Insurance Coverage** Indicate the type of health insurance coverage applicable by placing an X in the appropriate box.
1a	**Insured's ID Number** Enter the subscriber's ID number exactly as on their ID card, including the first three alpha-numeric characters.
2	**Patient's Name** Enter the patient's full last name, first name, and middle initial exactly as on their ID card. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
3	**Patient's Birth Date, Sex** Enter the patient's 8-digit birth date (MM/DD/YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. If sex is unknown, leave blank.
4	**Insured's Name** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt., Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	**Patient's Address** Enter patient's complete current address including street address, city, state, and zip code.
6	**Patient Relationship to Insured** Enter an X in the correct box to indicate the patient's relationship to insured.
7	**Insured's Address** Enter insured subscriber's complete address including street address, city, state, and zip code.
8	**Reserved for NUCC Use** Leave blank.

9 **Other Insured's Name**
If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the other insured enrollee's full last name, first name and middle initial.

9a **Other Insured's Policy or Group Number**
Enter the policy or group number of the other insured.

9b **Reserved for NUCC Use**
Leave blank.

9c **Reserved for NUCC Use**
Leave blank.

9d **Insurance Plan Name or Program Name**
Enter the other insured's insurance plan or program name.

10a-c **Is Patient's Condition Related To:**
When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.

10d **Claim Codes (Designated by NUCC)**
When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC.

11 **Insured's Policy, Group, or FECA Number**
Enter the insured's policy or group number as it appears on the insured's health care identification card.

11a **Insured's Date of Birth, Sex**
Enter the 8-digit date of birth (MM/DD/YYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

11b **Other Claim ID (Designated by NUCC)**
Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
When submitting to Property and Casualty payers, e.g., Automobile, Homeowner's, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:
Y4 Agency Claim Number (Property Casualty Claim Number)

11c **Insurance Plan Name or Program Name**
Enter the name of the insurance plan or program of the insured.

11d **Is there another Health Benefit Plan?**
When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d with other health benefit plan information.

12 **Patient's or Authorized Person's Signature**
Not applicable.

Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals.

13 **Insured's or Authorized Person's Signature**
Not applicable.

Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals

14 **Date of Current Illness, Injury or Pregnancy (LMP)**
Enter the 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.
Enter the applicable qualifier to identify which date is being reported.
431 Onset of Current Symptoms or Illness
484 Last Menstrual Period

15 **Other Date**
If applicable, enter another date related to the patient's condition or treatment.
Enter the date in the 8-digit (MM/DD/YYYY) format.
Enter the applicable qualifier to identify which date is being reported.
454 Initial Treatment
304 Latest Visit or Consultation
453 Acute Manifestation of a Chronic Condition
439 Accident
455 Last X-ray
471 Prescription
090 Report Start (Assumed Care Date)
091 Report End (Relinquished Care Date) 4
444 First Visit or Consultation

16 **Dates Patient Unable to Work in Current Occupation**

If the patient is employed and is unable to work in current occupation, an 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

17 **Name of Referring Provider or Other Source**

Enter the name first name, middle initial, last name followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words "self-referral."

17a **Other ID#**

The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

0B State License Number
1G Provider UPIN Number
G2 Provider Commercial Number
LU Location Number (This qualifier is used for Supervising Provider only.)

17b **NPI #**

Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

18 **Hospitalization Dates Related to Current Services**

Complete these dates when a medical service is furnished as a result of, or subsequent to, a related hospitalization. Enter the inpatient 8-digit (MM/DD/YYYY) hospital admission date followed by the 8-digit (MM/DD/YYYY)

discharge date (if discharge has occurred). If not discharged, leave discharge date blank.

19 **Additional Claim Information (Designated by NUCC)**
Use this to identify additional information about the patient's condition or the claim.

20 **Outside Lab? $Charges**
Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider. A "NO" mark or blank indicates that no purchased services are included on the claim. If "YES" is marked, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered. When lab procedures are performed by a party other than the billing physician/lab, identify procedures by adding the -90 modifier to the regular procedure code in Block 24D. Charges for these services cannot exceed the amount the outside laboratory charged.

21 **Diagnosis or Nature of Illness or Injury**
List no more than 12 ICD-10 CM codes in priority order with the primary diagnosis in the #1 position. Do not add any diagnosis description.

22 **Resubmission and/or Original Reference Number**
Not applicable.

23 **Prior Authorization Number**
Enter authorization number from Blue Shield or member's group (IPA), when applicable.

24 **Itemized Services**
Itemize each service rendered using the appropriate codes. Report only one service per line. This area of the claim form may not contain more than six lines of service. If you need to report more lines for the same patient, do so on separate claims. Also, claims cannot be continued from one to another; each claim must be separate.

24a **Date(s) of Service**
Enter the month, day, and year for each procedure, using the format "MMDDYY." For non-DME and radiation treatment leave 'to' date blank - no date ranging.

Durable Medical Equipment & Radiation Treatment Dates: Enter the month, day, and year for each procedure using the format "MMDDYY." Report all services provided on the same day for the same patient using only one claim

form to ensure correct benefit coverage. Monthly rentals must be coded with a date span. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24b **Place of Service**
Enter the two-digit Place of Service code. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
Refer to the Medicare website www.cms.gov for current place of services.

24c **EMG**
Leave blank. Completion of this block is not required.

24d **Procedures, Services, or Supplies**
Enter procedure, service or supply using the appropriate HCPCS/CPT procedure code and up to four modifiers. For assistant at surgery or anesthesia, always be sure to include applicable modifiers. For Telehealth HIPAA compliant video services, use Modifier 95 in 24d and place of service 02 in 24b.

Note: When you need to use more than four modifiers with a procedure code, enter Modifier 99 in Block 24D and list applicable modifiers in Block 19.

To report bi-lateral procedures, the services must be billed on two lines of the submitted claim. For example:

19368
19368-50

24e **Diagnosis Pointer**
Enter diagnosis code reference pointer from Block 21 to relate date of service and procedures performed to appropriate diagnosis. Place commas between multiple diagnosis reference pointers on the same line.

24f **Charges**
Enter the charge amount for the service performed. Do not enter dollar signs or decimal points. Always include cents.

24g **Days or Units**
Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

Anesthesia services must be reported as minutes. Units may only be reported for

anesthesia services when the code description includes a time period (such as "daily management").

DME monthly rentals must be coded with 30 units and accompanying date span. See 24a Date(s) of Service for more information.

24h **EPSDT/Family Plan**
Not applicable.

24i **ID Qualifier**
Enter in the shaded area of 24I the ZZ qualifier identifying the rendering provider Taxonomy number. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

24j **Rendering Provider ID #**
Enter the provider specialty Taxonomy Code (in the shaded area) and NPI (in the non-shaded area) for the performing or rendering provider or supplier.

Provider organizations such as medical group practices or clinics must include the rendering provider taxonomy code and the NPI of the rendering provider. Providers who bill as individual practitioners should also include on their claims the rendering provider specialty taxonomy code and the rendering provider NPI.

Note: Claims from group practices submitted without the rendering specialty taxonomy code in Block 24j will be rejected.

Enter provider specialty taxonomy code and NPI of the rendering provider or supplier. Several different providers or suppliers may be involved in providing services billed on the claim. If several members of a group shown in Block 33 have furnished services, this item is used to distinguish them.

25 **Federal Tax ID Number**
Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider.

26 **Patient's Account No.**
Enter the patient's account number.

27 **Accept Assignment?**
Enter an X in the correct box to report "Accept Assignment" for all payors.

28 **Total Charge**
Enter the amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

29 **Amount Paid**
Enter total amount paid by patient on submitted charges in Block 28.

30 **Reserved for NUCC Use**
Leave blank.

31 **Signature of Physician or Supplier Including Degrees or Credentials**
Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM/DD/YYY), 8-digit date (MM/DD/YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

32 **Service Facility Location Information**
Enter name and full address including the street number, city, state, and zip code of person, organization or facility performing services, if services were furnished in a hospital, clinic, laboratory, or any facility other than patient's home or provider's office. For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented or purchased at a retail store.

32a **NPI#**
Enter the NPI number of the service facility location in 32a.

32b **Other ID#**
Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number.

33 **Billing Provider Info & Ph #**
Enter the provider's or supplier's billing name, full address including the street number, city, state, zip code and phone number.

33a **NPI#**
Enter the NPI number of the billing provider or supplier

33b **Other ID#**
Enter the taxonomy code of the billing provider or supplier.

Providers are asked to submit claims electronically that do not have a record attached. Electronically submitted claims will be acknowledged within 2 days.

Using Electronic Data Interchange (EDI), providers submit claims and receive payments electronically for faster processing and payment. EDI allows paperless billing and payment for healthcare services and supplies and automates many types of routine inquiries. Please contact the EDI Help Desk at (800) 480-1221 with any questions about EDI.

If you still need to submit paper claims, use the Claims Routing Tool, located on Provider Connection at blueshieldca.com/provider under *Claims*, 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 claims 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**

The following provides a high-level, general overview of Blue Shield's payment processing logic. Please refer to Provider Connection at blueshieldca.com/provider under the *Claims* tab for the full payment policies. Please call Provider Information & Enrollment at (800) 258-3091 for additional information.

Blue Shield Claim Edits and Industry Standard Correct Coding

Blue Shield utilizes claims editing software that uses correct coding from industry standard sources, such as Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and health plan-developed policies, as applicable, during the claims adjudication process. Additional sources may be used as defined in the Claim Editing Payment Policy.

The claims editing software is also able to identify previously submitted historical claims that are related to current claim submissions, which may result in adjustments to claims previously processed.

Claims editing software will be updated periodically, without notification, to reflect the addition of newly released/revised/deleted codes and their associated claim edits, including but not limited to NCCI revisions, and health plan payment policies.

Manual Claim Review

There are numerous situations in which claims may undergo a manual review. When this takes place, the clinical documentation is compared to the submitted claims. If documentation does not support the codes submitted, the codes may be changed to reflect the documentation. If the submitted code is modified or changed after a manual claim review, the EOB message will further define the change.

Prescreen Claims

Blue Shield provides web access to Clear Claim Connection, a tool that enables providers to prospectively prescreen claims. Access and training instructions for Clear Claim Connection can be found on Provider Connection at blueshieldca.com/provider under *Claims*, then *How to submit claims.*

Professional and Ancillary Provider Payment Policies

Blue Shield has adopted payment policies for licensed and certified healthcare professional and ancillary provider types. Blue Shield Payment Policies are updated periodically to reflect the addition of newly released/revised/deleted codes without notification and can be found on Provider Connection at blueshieldca.com/provider under *Claims*, *Policies and Guidelines*, then *Payment Policies and Rules.*

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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)

CPT	Description
12013	Repair superficial wound(s)
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	Needle Insert w/o Inj 1 or 2 muscl
20561	Needle Insert w/o Inj 3 or more muscl
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

List of Office-Based Ambulatory Procedures

CPT	Description
20615	Treatment of bone cyst
20950	Fluid pressure, muscle
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

CPT	Description
29015	Application of body cast
29035	Application of body cast
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

List of Office-Based Ambulatory Procedures

CPT	Description
29740	Wedging of cast
29750	Wedging of clubfoot cast
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
42975	Dise eval slp do brth flx dx
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

CPT	Description
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
53454	Tprnl balo cntnc dev adjmt
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

List of Office-Based Ambulatory Procedures

CPT	Description
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
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 larynx EMG
64624	Destr 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

CPT	Description
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
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/rpt
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
0563T	Evac meibomian gld using heat bilat
0566T	Autol cell implt adps tiss njx implt
0588T	Rev or Rem isdns post tibial nrv
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record