Claims, Billing and Remittance

How, where and when to file a claim for electronic submissions.

Kansas City

BLUE KC NETWORK PROVIDER REFERENCE GUIDE

A reference manual for all Blue KC contracted network providers.

Additional Modules

Setup and Overview

- Blue KC Basics
- Credentialing and Contracting

Claims and Contacts

- BlueCard® Program
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- Contact Resource Directory

Additional Services

- Away From Home Care (AFHC)
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- Health Services
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- Specialty Services

Claims, Billing and Remittance

Each section is a clickable link.

Claims Filing

Participating Providers must file claims for all Blue Cross and Blue Shield of Kansas City (Blue KC) members, as well as for members who have BCBS coverage through other plans, for all Provider services. All claims must be submitted as a complete and accurate electronic form, including appropriate CPT®, HCPCS, ICD-10 and revenue codes, in accordance with Blue KC's Policies and Procedures after providing services to a member. All submissions must adhere to all applicable medical coding guidelines, including, but not limited to, National Correct Coding Initiatives (NCCI), and policy standards.

Always include the alphanumeric prefix portion of the member identification number on all claim forms.

Timely Filing

We emphasize that a key step in the claims payment process is for a Provider's accounts receivable department to do complete remit reconciliation and then perform any necessary follow-up. A remit reconciliation confirms that the claim has been received.

Providers must submit completed and accurate claims of covered services to members within 180 days after date of service or 90 days from payment from primary insurance to receive payment from Blue KC. If not submitted within this period, claims will not be honored and the Provider will not bill members for services associated with such claims. Provider must obtain a signed release of information and assignment of benefit form from all members.

Timing Overview	
Primary	In the Blue KC Physician Network Agreement, we ask that claims be filed within 30 days of the date of service but no later than 180 days in order to be considered for payment.
Secondary	Claims should be filed within 180 days of the date of service or 90 days from the primary carrier's payment date with the Primary payer remittance. Blue KC accepts secondary claims electronically.
Next Step	
Claim Verification (Follow-Up at 30 days if no remittance)	Visit Providers.BlueKC.com or call the Provider Hotline. See the Contact Resource Directory for claims related information.
Next Step	
Claim Inquiry eForm	Submit within 12 months of the original paid date for claims previously processed by Blue KC
Medical Policy Issues	Check Medical Policy at Providers.BlueKC.com.
Payment Policy	Check Provider Payment Resources at Providers.BlueKC.com.

Claims which are not timely submitted shall not be honored and the Provider agrees not to bill members for services associated with such claims.

Resubmitting Claims

The majority of "clean" claims received by Blue KC are processed rapidly and, therefore, payment or a denial can be anticipated within 30 days. To verify claim status please check Providers.BlueKC.com or call the Provider Hotline (see Contact Resource Directory for details). For adequate processing time, allow at least 30 days from the date of claim submission before following up. Providers should avoid sending duplicate bills to Blue KC sooner than 30 days after original submission. If bill is duplicated, the Provider may be required to repay amounts or it may be deducted from subsequent amounts due. A corrected claim will not be accepted after an official overpayment notice has been sent to the provider outlining the reason for the recoupment and dispute process.

What to Include

- Always remember to include the alphanumeric prefix portion of the member identification number on all claim forms.
- Services billed on the 837P (CMS-1500) should include the name and NPI of the performing Provider on each line item.
- A local member's Blue KC ID card will be imprinted with the plan/network name (examples: **Preferred-Care PPO**, **Preferred-Care Blue PPO**, **Blue-Care HMO** or etc.) and the Blue KC name and logos (see the Blue KC Basics Module for member ID card examples).
- Use Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and International Classification of Diseases (ICD-10) codes. Please use the current codes reflective of the date of service of the claim.

Where to File

Claims filing information is printed on the back of a member's ID card. If a physician is unsure where to file a claim, please call the **Provider Hotline** (see Contact Resource Directory for details).

Electronic Claim Submission

Claims Acknowledgement (277CA)

It is important to familiarize yourself with procedures within the Administrative Services of Kansas (ASK) clearinghouse. It is a Provider's responsibility to become familiar with the processes and procedures of the clearinghouse in regard to their handling and distribution of the 277CA, so please initiate this discussion whenever there is a change with software vendors and/or clearinghouses. Failure to reconcile the 277CA can result in Blue KC not receiving all the initial electronic claims that were intended to be submitted.

The 277CA provides detailed information on all electronic claims that have been accepted or rejected. This information is vital since it represents the actual accepted claims that will be forwarded to Blue KC for processing as well as rejected claims that must be corrected and resubmitted.

ASK delivers a 277CA back to the original submitter (trading partner) of the electronic claim file. Some trading partners, such as clearinghouses, may reformat, repackage or bundle the information in the 277CA into other various printed and electronic reports.

See the ASK website for more information about:

- Electronic claim processes and the 277CA with training examples.
- Register for ASK email notifications.

Please contact the Administrative Services of Kansas (ASK) (see Contact Resource Directory for details) with any questions related to electronic claim submission.

- Send Type I and/or Type II NPI(s) depending how the Provider is set up with Blue KC.
- ASK accepts electronic claims directly or through a clearinghouse.
- After a claim file has been submitted to ASK, a Claims Acknowledgement (277CA) is produced which indicates the status of each claim: rejected, or accepted. ASK will provide a 277CA to whomever submits the claim(s).
- If claim was rejected, it must be corrected and resubmitted within the 180 days timely filing requirement.
- Accepted claims are transmitted to Blue KC for processing.
- If no payment or response is received within 30 days, check Providers.BlueKC.com or call **Provider Hotline** for status.
- Electronic claim submissions is the preferred method and saves providers time and money.

Blue KC expects the original claim submission to be accurate and fully reflect all information gathered during the initial patient encounter. However, when a corrected claim is necessary, please note the requirements and information listed below.

Claim corrections submitted without the appropriate data elements will be denied and the original claim will not be adjusted.

We will no longer accept corrected paper claims. As of February 1, 2019, Blue KC only accepts corrected claims electronically. Send a Corrected Electronic Professional Claims (837P). Complete corrected claim at Providers.BlueKC.com.

Claims Data Elements – Electronic Corrected Claims

Name of Data Element	837P or 837I Loop and Data Element	Data Element Information
Claim Frequency Type Code	2300 / CLM05 - 3	**7** (Replacement of a Prior Claim) **8** (Void of a Prior Claim)
Payer Claim Control Number Qualifier Original Reference Number Qualifier	2300 / REF01	**F8**
Payer Claim Control Number Original Claim Number	2300 / REF02	The original Blue KC assigned **claim number**.
Claim Note Reference Code	2300 / NTE01	**ADD** (Additional Information)
Claim Note Text	2300 / NTE02	**Free-form text field** (80 characters) to provide a description of correction.

Submitting Corrected Claims

Submit a Corrected Electronic Claim	Do not Submit a Corrected Electronic Claim*
Original claim was denied for other carrier information. Send a corrected claim with the necessary COB data elements.	Claims that have been denied for medical necessity.
Changes related to date of service, CPT, HCPCS, DX code, modifiers, revenue code, type of bill or units. These are just some examples of changes that could be made.	Claims that have been denied for investigational or experimental services.
Original claim was denied for additional information, such as: NDC code, CPT or HCPCS description (NOC code). Send corrected claim with full code description in the claim note text.	Claims with services that have been bundled or denied inclusive of another service.
Original claim for DME, Clinical Lab or Specialty Pharmacy denied for no referring physician. Send corrected claim with the referring physician information.	Claims that have been denied for lack of information request for additional clinical documentation (office notes, surgical notes, reports, etc.).

**Use a claim inquiry via* Providers.BlueKC.com

A corrected claim will not be accepted after an official overpayment notice has been sent to the provider outlining the reason for the recoupment and dispute process. To dispute an overpayment notice, see the Request for Reconsideration section, below.

How will Blue KC handle my corrected electronic claim (837P or 837I)?

Regular (local) Business and Federal Employee (FEP):

- Original claim will be voided.
- The corrected claim will be processed and paid, if applicable, on the same remittance advice.

BlueCard (ITS):

- Original claim will be voided.
- The corrected claim will be reprocessed and paid, if applicable, on the different remittance advices.
- Because these claims are going to the members' home plan, please allow 30 days for the corrected claim to process.

What if a claim is returned or rejected?

- Rejected claims should not be submitted as corrected claims.
- Only claims that have completed adjudication should be submitted as corrected.
- When sending a corrected electronic claim, providers must re-send the claim in its entirety including the corrections.

How will Blue KC handle paper corrected claim inquiries?

- Paper corrected claim inquiries will be returned to the Provider with a handout directing the Provider to file an electronic adjustment.

What happens when a corrected claim is completed on the Blue KC Provider Portal?

- Corrected claim inquiries completed at Providers.BlueKC.com are imaged and processed. The corrected claim will then follow the same steps as indicated above.

Payments of Claims

Blue KC will process or transmit complete and accurate claims for payment:

- In accordance with the Benefit Plan, Policies and Procedures, and the Payment Rate
- The net of amounts recoverable from other third-party payors through Coordination of Benefits
- The net of any applicable copayments, coinsurance, cost share, or deductibles

Complete, accurate and clean claims shall contain all information required to allow Blue KC to adjudicate and pay the claim without further investigation. This information includes identification of member and Provider, correct Blue KC billing numbers, services provided and appropriate standard diagnosis and procedure codes.

Blue KC will either process and pay claims without returning claim to Provider, or return in a timely manner to request further information.

Payments should be made within 30 days after the claim is made final. Payor shall pay Provider for services or notify Provider of delay or denial. For claims subject to provisions of RSMo 376.383, claims not paid within 45 days shall be subject to interest charges. Blue KC will notify Provider of incomplete claims in a timely manner.

Member Billing

Collection of Member Copayment, Coinsurance, Cost Share or Deductible

Provider shall only collect all member copayments, coinsurance, cost share or deductible amounts after services are rendered, and shall not waive such amounts. The payment rate agreed upon must be accepted as payment in full of payor's financial responsibility. Blue KC shall make remaining payments directly to Provider for covered services. Provider cannot bill member for the difference between full charges and payment rate, and can only bill, charge or collect remaining cost from Blue KC. The Provider accepts the payment rate as payment in full of the payors financial responsibility for services provided to members.

Blue KC will not reimburse for Physician/Nurse/Provider phone calls for prescriptions. Members should not be billed for Physician/Nurse/Provider phone calls for prescriptions.

Provider can negotiate arrangements with the member for payment of copayment, coinsurance, cost share or deductible, but providers shall not accept payments from any third parties.

Payment collection from a member after Blue KC has processed the claim and issued a remittance advice:

- **Deductible**: A specific amount the member pays toward covered services before Blue KC begins to make payments.
- **Coinsurance**: A percentage of Blue KC reimbursement allowed for a covered service that the member is required to pay after they have met their deductible.

Payment collection from a member at the time of a visit:

- **Copayment**: A specified dollar amount which the member is responsible for paying at the time of an office visit.
- **Non-covered service amounts**: Services that are not eligible for payment under the member's policy or benefit plan.

Participating providers may not collect from a member any amount above the established Blue KC allowable for a corresponding covered service.

The Blue KC remittance advice shows the amount a provider may bill the member and the amount the provider agrees to write-off, pursuant to contract terms.

Non-Covered Services

Participating providers may only collect payment from a member for a non-covered service if the member signs a written consent confirming that the member agrees to be responsible for payment of the service(s) prior to the service(s) being rendered. The written consent must include the following:

- The specific service(s) to be provided
- A statement that the service(s) is or are not covered by Blue KC
- The estimated cost of the service(s)
- A statement that the member has agreed, in advance, to receive and pay for the specific service(s)
- A statement that the member will not be obligated to pay for the service(s) if it is later determined that the service(s) are covered by Blue KC

It is important that providers retain a copy of the member's signed consent and provide it to Blue KC in the event of a dispute regarding financial responsibility.

For further assistance, providers may call the **Provider Hotline** (see Contact Resource Directory for details).

Routine Examinations and Screenings

It is important that providers be familiar with how to bill correctly for services that may be part of routine physical examinations. It is critical that these services be reported with the appropriate type of services, procedures and diagnosis codes.

While Blue KC provides wellness benefits that are mandated by Kansas and Missouri state and federal laws, most Blue KC benefit plans provide coverage for routine preventive screenings that are not wellness benefits, based on recommendations from the Blue Cross and Blue Shield Association and guidelines set forth by the American College of Physicians.

Member Eligibility

To determine if a member is eligible for preventive care benefits under his/her contract, a Provider may check Providers.BlueKC.com or call the **Provider Hotline** (see Contact Resource Directory for details).

Care Guidelines

The guidelines set forth to determine what services are considered preventive are updated periodically. Refer to cdc.gov/vaccines to access the most up-to-date immunization schedules. Blue KC's current Preventive Healthcare Guide is located at BlueKC.com, click *Living Healthy* then select *Preventive Guidelines*.

Coordination of Benefits

Coordination of Benefits Coordination of Benefits (COB) is a cost-containment provision of group contracts which helps to avoid duplicate payment of covered services. COB is applied when a member is enrolled with Blue KC and another insurance plan. COB assures that services are not reimbursed at more than 100 percent of total charges. Please note that Blue KC accepts electronic claims (837) with COB data.

Blue KC and Provider shall coordinate benefits with the non-duplication provisions of the member's Benefit Plan and applicable law. Third-party payment collection must also follow identification procedures for proper Coordination of Benefits.

The providers must ask members for duplicate or COB coverage information, and shall notify Blue KC of any potential or actual duplicate COB coverage through Blue KC's claims filing practices.

Any payment incorrectly collected for services of a third party responsibility should be returned to Blue KC by Provider. Provider shall not withhold services nor require member to pay for services pending determination of primary responsibility.

When another payor is involved, the total of all payments will not exceed the amount specified in the member's Benefit Plan. Blue KC shall never pay more than the Blue KC allowed amount. If another payor is involved, the Provider shall write off any balance as if Blue KC was the sole source of payment.

Participating providers may not collect from a member any amount above the established Blue KC allowable for a corresponding covered service.

Blue KC's liability for members with additional health insurance coverage will be governed by the member's Benefit Plan.

Coordination with Medicare

Employer group insurance is frequently primary to Medicare benefits for the working aged, and beneficiaries with renal and other disabling conditions. Blue KC may pay secondary for members enrolled in an individual plan who are eligible for or enrolled in Medicare.

If Medicare is primary, the Provider must accept Medicare as form of payment. Blue KC, or the applicable Provider, will make payment only for Medicare cost sharing amounts.

Multiple Insurance Plans

Physicians can help in the Coordination of Benefits process by asking members if they have other insurance in addition to Blue KC. It is possible for Blue KC to be the insurer of both spouses under different contracts.

If members have more than one insurance plan, always include the following information in the appropriate box on the claim form:

- Name of other insurance company.
- Policyholder's name.
- Identification number.

No-fault Automobile Insurance

State insurance commissions regulate whether insurance companies can coordinate benefits with no-fault automobile insurance coverage.

- **Kansas**: Benefits are coordinated with the no-fault insurer. Please check the Auto Accident box on the CMS 1500 claim form.
- **Missouri**: There is no Coordination of Benefits with no-fault carriers for Missouri residents.

Worker's Compensation

Work-related accidents are not covered under most Blue KC contracts.

If services provided by the Provider's office are the result of a member's on-the-job injury, specific information regarding the accident or condition is always needed on the claim:

- An indication that the injury was work-related (CMS 1500 employment box).
- Related diagnoses in appropriate fields on the claim form.

Secondary Coverage Guidelines

The determination of which insurance carrier's allowable applies and which plan pays primary is determined in accordance with the member's health plan and the National Association of Insurance Commissioners (NAIC) guidelines. The Blue KC Provider Agreement does not govern these determinations.

The following guidelines apply when Blue KC is a member's secondary health plan, except when the application of such guidelines could cause either party to violate any federal or state law.

When an individual is covered by two or more health plans, Blue KC's secondary payment will vary based on the rules governing a member's health plan. The Provider must "write off" any amount that exceeds the applicable allowable described below. Once the appropriate allowable is determined, the Provider should expect to receive payment from multiple health plans and/or the member that equals the allowable.

For purposes of Secondary Coverage Guidelines, allowable means the amount the Provider has agreed to accept as payment for the service or supply.

Missouri Group Insured Health Plans

When determining the secondary payment under these programs, Blue KC applies the primary carrier's allowable. However, Blue KC's secondary payment will never exceed the amount of the member's responsibility determined by the primary program.

The group purchaser is located in Missouri.

Kansas Group Insured Health Plans

When determining the secondary payment under these programs, Blue KC applies the highest of the allowables between the two or more programs.

The group purchaser is located in Kansas.

Self-Insured or ASO Plans

When determining the secondary payment under these programs, Blue KC applies the allowable as required in the plan sponsor's plan documents.

Federal Employee Plan

When determining the secondary payment under this program, FEP applies the lower of the allowables between the two or more programs.

BlueCard (Other Blue Cross and Blue Shield Plans)

When determining the secondary payment under these plans, the home plan determines what allowable applies in accordance with state law and plan documents.

Due to the variety of ways that an allowable may be determined, providers should not expect that claims will be processed under the same rule on each claim that is processed. Your allowable may be determined in several ways and thus the amount of the secondary payment will differ.

Medicare

Medicare Part A refers to inpatient institutional services, and Part B refers to outpatient and professional services. When Blue KC is secondary to Medicare, the following guidelines apply:

Provider Filing with Medicare

Please DO NOT file with Blue KC and Medicare simultaneously. The Provider must wait until receipt of the Medicare remittance advice. After receipt of the Medicare remittance advice, please determine if the claim was automatically crossed-over to the member's supplemental insurance.

Crossed-over Claims

If the claim was crossed-over, the paper and electronic (835) remittance advice should have Remark Code MA 18, which states, "The claim information is also being forwarded to the member's supplemental insurer. Send any questions regarding supplemental benefits to them."

If the claim was crossed-over, please DO NOT file the claim with Blue KC unless it has been 30 days and the cross-over claim has not been received.

Claims and Eligibility

Inquires

Blue KC Provider Portal

All claim inquiries should be submitted through the provider portal at Providers.BlueKC.com. Check claim status or review paid claims (plus eligibility and benefits) or view BlueCard responses and inquiries; click Claims/Eligibility.

Corrected Claims

For instructions, see the table in this module titled "Submitting Corrected Claims."

Electronic Inquiries

Real-time eligibility request and response (270/271) or claim status request and response (276/277).

Claim Inquiry eForm

For efficient handling of a request, please complete a claim inquiry form. There is an eForm in the forms section at Providers.BlueKC.com.

Include all necessary information on the form in order for the claim to be properly researched:

- Claim number.
- Date of service.
- The Blue KC 8-digit Provider/group number.
- The policy holder's/insured's name (if different from the member) and ID number.

Claims not Crossed-over

If the remittance advice does not indicate the claim was crossed-over, please file the claim to Blue KC. Please go to Providers.BlueKC.com or call the **Provider Hotline** (see Contact Resource Directory for details), with questions regarding COB or Medicare supplemental reimbursement.

Overpayment Policy

Blue KC Overpayments

All overpayments or incorrect payment of either parties must be identified and recovered.

Blue KC will recover any overpayments, payments related to billing code errors or incorrect payments by credit transactions on the remittance advice. Blue KC may offset the full amount of any incorrect payment and reissue payment for the correct amount. Should the provider not receive an overpayment letter outlining the reason for recovery, the provider may submit a claim inquiry within 12 months of the date of the recovery.

For claims subject to RSMo 376.384, Blue KC will not request a refund or offset against a claim more than 12 months after Blue KC's payment of the claim except in cases of fraud or misrepresentation by the Provider.

Unsolicited Refunds

To help reduce the administrative cost for providers, Blue KC will no longer accept unsolicited checks effective January 1, 2025. If you have identified a potential overpayment, you can submit a request for review of possible overpayment and check "Overpayment" on our Claim Inquiry form. To find this form, log on at Providers.BlueKC.com, click on "Forms" under "Quick Links" on the home page and look under "Claim Forms." Any unsolicited check received will be returned to the provider requesting a claim inquiry for review of potential overpayment.

In filling out the details on the form, providers can include the claim information and reasons they feel the claim is overpaid. If the potential overpayment is valid, Blue KC will offset the claim to recoup the overpayment. If you do not receive frequent payments (two or more monthly payments in a three-month time span), we will respond to the claim inquiry form by letting you know that we will send you an overpayment letter for you to send back to us with the payment.

Member Overpayments

Upon receipt of a remittance advice for insured Blue KC local business, if a Provider collected more than the amount indicated as member responsibility on the remittance advice, it must be refunded to the member no later than 30 days after receipt of the remittance advice. A refund is not required if the member owes for previous services rendered and the overpayment is applied to the outstanding balance.

Claims and Other Records

HIPAA

Blue KC and Providers are each separate covered entities for purposes of the Health Insurance Portability and Accountability Act of 1996, as amended, and its implementing regulations found at 45 C.F.R. Parts 160 and 164. Blue KC and Providers are permitted to exchange information for treatment, payment, and health care operations. Providers are responsible for ensuring compliance with HIPAA, Part 2 and applicable state law(s) when entering, transmitting or accessing information to submit a claim or exchange other information with Blue KC. Providers are responsible to assess whether they have legal authority (including written authorization, where required) to use or disclose such information.

The Provider must comply with all HIPAA requirements for electronic transactions including transactions through a clearinghouse, intermediary, subcontractor or other agent.

Records Subject 42 C.F.R. Part 2

These provisions are applicable to all network and out-of-network providers that provide information records to Blue KC that contain Patient Identifying Information subject to 42 C.F.R. Part 2 ("Part 2 Rule").

For purposes of this "Claims and Other Records Subject 42 C.F.R. Part 2" section, all capitalized terms not defined in this section shall have the meanings provided in 42 C.F. R. § 2.11.

Identification as a Part 2 Program

All providers who are a Part 2 Program or who operate a subpart that is a Part 2 Program must notify Blue KC.

Substance Use Disorder Claims

A Part 2 Program is prohibited by the Part 2 Rule from disclosing Patient Identifying Information to Blue KC through the submission of a claim without first obtaining the patient's consent. Blue KC is prohibited by law from using Patient Identifying Information to pay any claim (or to process other information) in the absence of such consent. Accordingly, by submitting any claim (or other record) that contains Patient Identifying Information to Blue KC, Provider that is a Part 2 Program represents and warrants that Provider has first obtained patient consent in compliance with 42 C.F.R Part 2 to allow disclosure to Blue KC and Blue KC's use of the information for payment and health care operations. Blue KC reserves the right to deny payment of claims (and the right to refuse to process other information) in the event that Provider fails to obtain such consent.

Where provider has already notified Blue KC that it is a Part 2 Program or has a subpart that is a Part 2 Program, Blue KC does not require that provider further designate the claim information as subject to the Part 2 Rule. However, if provider desires to communicate application of the Part 2 Rule as part of the claim submission, the following information should be added to the 837:

2300/NTE 01 = ADD
2300/NTE 02 = 42 CFR Part 2 prohibits unauthorized disclosure of these records.

Provision of Part 2 Records and Information

Providers periodically submit records or other information to Blue KC as requested by Blue KC, as required by a Provider Agreement or to support a claim. If the records or other information submitted to Blue KC includes Patient Identifying Information subject to the Part 2 Rule, either because Provider is a Part 2 Program or provider received such information from a Part 2 Program, provider may only provide the records or information to Blue KC if provider has obtained patient consent for such disclosure. Where the records or information relate to a claim previously submitted to Blue KC, the original consent for the claim submission may satisfy this requirement.

Provider is also required to notify Blue KC that the information is subject to the Part 2 Rule through inclusion of specific notice (the "Part 2 Disclaimer"). Accordingly, provider shall include the Part 2 Disclaimer with any record or information that contains Patient Identifying Information when submitting the record or information to Blue KC.

The Part 2 Disclaimer is:

- "42 CFR Part 2 prohibits unauthorized disclosure of these records"

Consent Requirements

Provider is responsible for ensuring that all patient consents obtained comply with requirements of the Part 2 Rule, including, but not limited to required elements under 42 C.F.R. 2.31. When completing the consent form, provider must indicate that the disclosure will be made to Blue KC "for payment and/or health care operations activities." Blue KC reserves the right to deny payment of claims (and the right to refuse to process other information) in the event that provider fails to obtain such consent.

Chiropractic

MO Statute: 376.391

Copayments for Chiropractic Services, Cap 376.391

A health benefit plan or health carrier, as defined in section 376.1350, including but not limited to preferred Provider organizations (PPO), independent physician associations, third-party administrators or any entity that contracts with licensed health care providers shall not impose any copayment that exceeds fifty (50) percent of the total cost of providing any single chiropractic service to its enrollees. (L. 2009 H.B. 577).

Remittance

Blue KC sends a weekly remittance advice statement to participating providers. This statement provides detailed information for any claim processed (paid or denied) during that week. The Blue KC remittance advice shows the amount a Provider may bill the member and the amount the Provider agrees to write-off, pursuant to contract terms.

Payment Errors or Remittance Advice Problems

Procedure

- If a Provider receives an incorrect payment (e.g. duplicate payment or a payment to an incorrect physician), or a remittance advice does not balance to the payment received, please deposit the check. Do not return Blue KC's check.
- You may submit the error one of the following ways:
    i. Submit questions via Contact Us at Providers.BlueKC.com. Use *Claims* as the type of inquiry.
    ii. Submit a claim inquiry eForm through the provider portal at Providers.BlueKC.com.
    iii. Call the **Provider Hotline** (see Contact Resource Directory).

The problem will be routed to the appropriate area for correction, and every effort will be made to resolve the problem quickly.

An adjustment will be made to a future remittance advice to account for (or balance) the reported problem. If appropriate, incorrect payments will be deducted at that time.

Request for Reconsideration

If a Provider receives an aggregate overpayment due to excess reimbursement from multiple group insurance carriers, please do not refund the overpayment to the member. Call the **Provider Hotline** (see Contact Resource Directory) on where the overpayment should be sent.

Providers may request reconsideration of adjudicated claim. Blue KC may adjust an adjudicated claim if it is determined that the claim was incorrectly paid or denied.

Providers must give Blue KC written notice of a request for reconsideration within the timeline specified in the overpayment notice. If the Provider fails to request reimbursement in a timely manner, the Provider can't bill or seek reimbursement from a member that was denied.

Interest on Claims

If a claim received by Blue KC is not paid within the guidelines established by the states of Missouri or Kansas, Blue KC will pay interest to the Provider if required by law. If additional information is required by Blue KC to process the claim, the claim must be paid within a specified period from the receipt of this new information to avoid interest charges.

Reporting Interest

Interest is reported on the remittance advice in two areas:

- At the claim level.
- At the summary level by line of business.

No Interest Paid

Claims related to Administrative Services Only (ASO) business, Medicare Advantage, certain rental business and FEP groups are exempt from state interest statutes. No interest will be paid on these claims.

Refunds to Covered Individuals

Physician Network Agreement Article/Agreement/Contract

Within 30 days of receiving payment from payor, the physician agrees to remit any credit balances due to Covered Individuals from physician for covered services. If Blue KC has been required by statute to pay the Physician any interest, as a part of its claims payment process, the Physician is required to reimburse a pro rata share of that interest payment to the Covered Individual.

Claims Payments and Remittance

Member Responsibility

Participating physicians agree to accept the Blue KC fee schedule allowable as payment in full and to not bill the member for any amount over this allowable. The member is responsible for any deductible, coinsurance, copayments and non-covered amounts.

The Blue KC fee schedule is proprietary and confidential information. Notwithstanding the confidential nature of this information, Blue KC and Provider may disclose confidential information, including, but not limited to payment rates, quality metrics, and cost of care information, to members, referring providers, payors, plan sponsors, or any other individual or entity as required by law to provide transparency regarding the potential or actual cost or quality of health care services.

Electronic Remittance (835)

The 835 will allow automatic accounts receivable posting and is one of the major cost savings of the HIPAA implementation. If a Provider is interested in implementing the benefits of an electronic remittance advice, please contact your practice management system vendor or clearinghouse. If a Provider receives EFT and 835, Blue KC will mail paper remits for only 60 days from the time EFT and 835 move date. Your office will always be able to access paper remits at Providers.BlueKC.com.

Either the vendor, clearinghouse or the Provider will need to contact Administrative Services of Kansas (ASK) (see Contact Resource Directory) for set up.

Electronic Funds Transfer (EFT)

If a Provider is not already set up for EFT, please complete the Provider Electronic Funds Transfer Application in the Forms section at Providers.BlueKC.com. Providers will receive faster payments when deposited directly into a bank account.

Provider Payments

Providers may receive up to eight payments with each weekly remittance advice. One payment is issued for each of the following eight Blue KC lines of business:

- BlueCard
- Blue-Care HMO
- Blue Cross and Blue Shield
- Federal Employee Program (FEP)-Standard
- Federal Employee Program (FEP)-Basic
- Federal Employee Program (FEP)-Blue Focus
- Medicare Advantage PPO
- Medicare Advantage HMO

Each line of business may include several products. For example, a *Blue Cross and Blue Shield* check may include Preferred-Care Blue® PPO, Preferred-Care PPO, Medicare Supplemental or Traditional.

Format and Examples

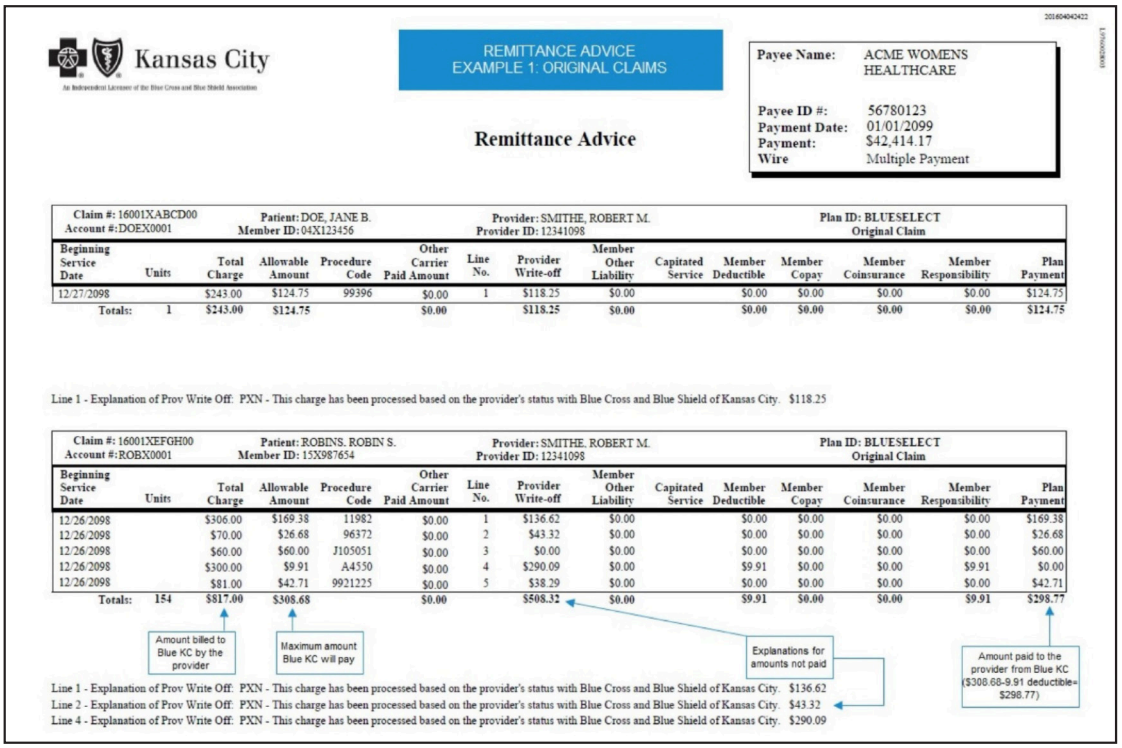
The format of the remittance advice is divided into three parts for every check or payment made to a Provider. The parts are as follows:

- Original Claims (example 1).
- Adjusted Claims (examples 2 void, 3 supplemental and 4 overpayment).
- Payment Summary (example 5).

A summary line is presented for each Provider of service per product.

The examples on the pages that follow represent the format of the Professional Provider Remittance Advice. The Facility Remittance Advice is slightly different.

Example 1 – Original Claims



Kansas City

REMITTANCE ADVICE
EXAMPLE 1: ORIGINAL CLAIMS

Remittance Advice

Payee Name:	ACME WOMENS HEALTHCARE
Payee ID #:	56780123
Payment Date:	01/01/2099
Payment:	$42,414.17
Wire	Multiple Payment

Claim #: 16001XABCD00 Account #:DOEX0001 | Patient: DOE, JANE B. Member ID: 04X123456 | Provider: SMITHE, ROBERT M. Provider ID: 12341098 | Plan ID: BLUESELECT Original Claim

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
12/27/2098		$243.00	$124.75	99396	$0.00	1	$118.25	$0.00		$0.00	$0.00	$0.00	$0.00	$124.75
Totals:	1	$243.00	$124.75		$0.00		$118.25	$0.00		$0.00	$0.00	$0.00	$0.00	$124.75

Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $118.25

Claim #: 16001XEFGH00 Account #:ROBX0001 | Patient: ROBINS, ROBIN S. Member ID: 15X987654 | Provider: SMITHE, ROBERT M. Provider ID: 12341098 | Plan ID: BLUESELECT Original Claim

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
12/26/2098		$306.00	$169.38	11982	$0.00	1	$136.62	$0.00		$0.00	$0.00	$0.00	$0.00	$169.38
12/26/2098		$70.00	$26.68	96372	$0.00	2	$43.32	$0.00		$0.00	$0.00	$0.00	$0.00	$26.68
12/26/2098		$60.00	$60.00	J105051	$0.00	3	$0.00	$0.00		$0.00	$0.00	$0.00	$0.00	$60.00
12/26/2098		$300.00	$9.91	A4550	$0.00	4	$290.09	$0.00		$9.91	$0.00	$0.00	$9.91	$0.00
12/26/2098		$81.00	$42.71	9921225	$0.00	5	$38.29	$0.00		$0.00	$0.00	$0.00	$0.00	$42.71
Totals:	154	$817.00	$308.68		$0.00		$508.32	$0.00		$9.91	$0.00	$0.00	$9.91	$298.77

Amount billed to Blue KC by the provider

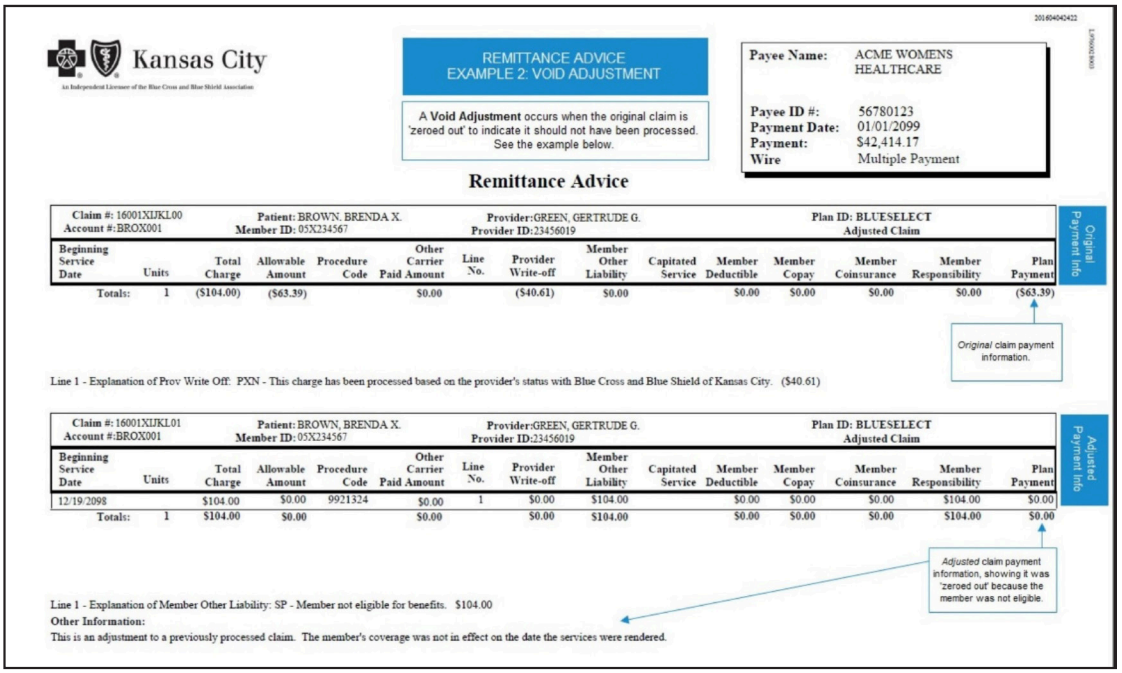
Maximum amount Blue KC will pay

Explanations for amounts not paid

Amount paid to the provider from Blue KC ($308.68-9.91 deductible= $298.77)

Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $136.62
Line 2 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $43.32
Line 4 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $290.09

Example 2 – Void Adjustment



Kansas City

REMITTANCE ADVICE
EXAMPLE 2: VOID ADJUSTMENT

A **Void Adjustment** occurs when the original claim is 'zeroed out' to indicate it should not have been processed. See the example below.

Remittance Advice

Payee Name:	ACME WOMENS HEALTHCARE
Payee ID #:	56780123
Payment Date:	01/01/2099
Payment:	$42,414.17
Wire	Multiple Payment

Claim #: 16001XIJKL00 Account #:BROX001 | Patient: BROWN, BRENDA X. Member ID: 05X234567 | Provider: GREEN, GERTRUDE G. Provider ID: 23456019 | Plan ID: BLUESELECT Adjusted Claim

Original Payment Info

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
Totals:	1	($104.00)	($63.39)		$0.00		($40.61)	$0.00		$0.00	$0.00	$0.00	$0.00	($63.39)

Original claim payment information.

Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. ($40.61)

Claim #: 16001XIJKL01 Account #:BROX001 | Patient: BROWN, BRENDA X. Member ID: 05X234567 | Provider: GREEN, GERTRUDE G. Provider ID: 23456019 | Plan ID: BLUESELECT Adjusted Claim

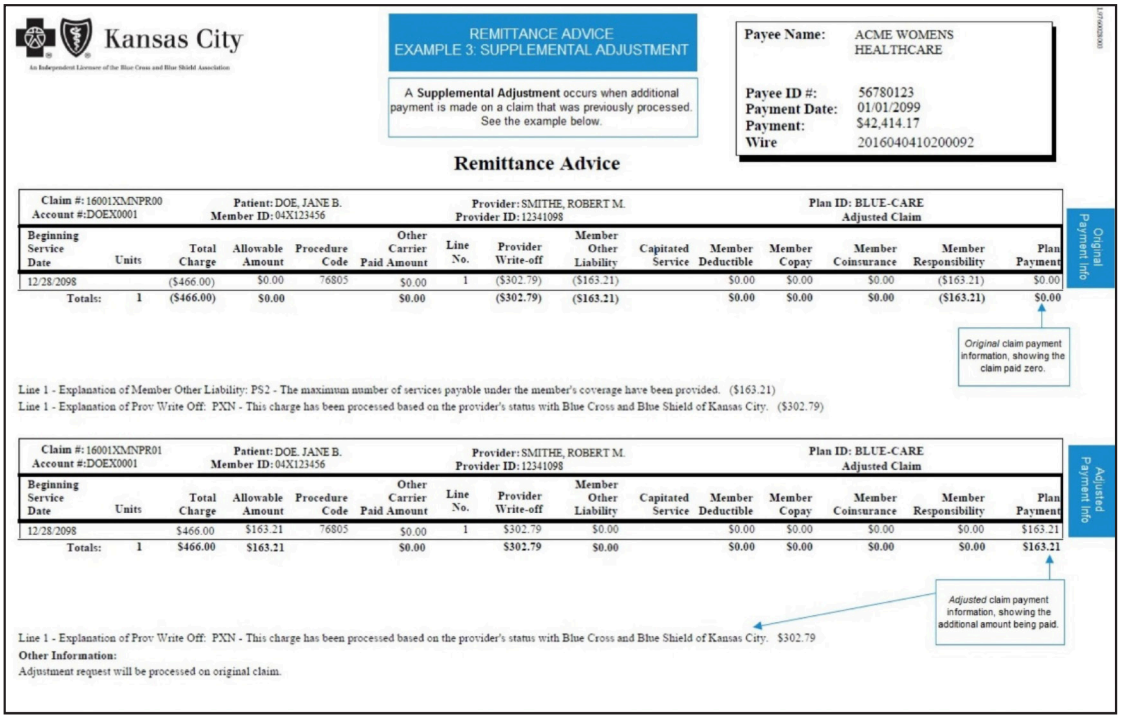
Adjusted Payment Info

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
12/19/2098		$104.00	$0.00	9921324	$0.00	1	$0.00	$104.00		$0.00	$0.00	$0.00	$104.00	$0.00
Totals:	1	$104.00	$0.00		$0.00		$0.00	$104.00		$0.00	$0.00	$0.00	$104.00	$0.00

Adjusted claim payment information, showing it was 'zeroed out' because the member was not eligible.

Line 1 - Explanation of Member Other Liability: SP - Member not eligible for benefits. $104.00
Other Information:
This is an adjustment to a previously processed claim. The member's coverage was not in effect on the date the services were rendered.

Example 3 – Supplemental Adjustment



Kansas City

REMITTANCE ADVICE
EXAMPLE 3: SUPPLEMENTAL ADJUSTMENT

A **Supplemental Adjustment** occurs when additional payment is made on a claim that was previously processed. See the example below.

Payee Name: ACME WOMENS HEALTHCARE

Payee ID #: 56780123
Payment Date: 01/01/2099
Payment: $42,414.17
Wire 201604041020092

Remittance Advice

Claim #: 16001XMNPR00 Account #:DOEX0001 | Patient: DOE, JANE B. Member ID: 04X123456 | Provider: SMITHE, ROBERT M. Provider ID: 12341098 | Plan ID: BLUE-CARE Adjusted Claim

Original Payment Info

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
12/28/2098		($466.00)	$0.00	76805	$0.00	1	($302.79)	($163.21)		$0.00	$0.00	$0.00	($163.21)	$0.00
Totals:	1	($466.00)	$0.00		$0.00		($302.79)	($163.21)		$0.00	$0.00	$0.00	($163.21)	$0.00

Original claim payment information, showing the claim paid zero.

Line 1 - Explanation of Member Other Liability: PS2 - The maximum number of services payable under the member's coverage have been provided. ($163.21)
Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. ($302.79)

Claim #: 16001XMNPR01 Account #:DOEX0001 | Patient: DOE, JANE B. Member ID: 04X123456 | Provider: SMITHE, ROBERT M. Provider ID: 12341098 | Plan ID: BLUE-CARE Adjusted Claim

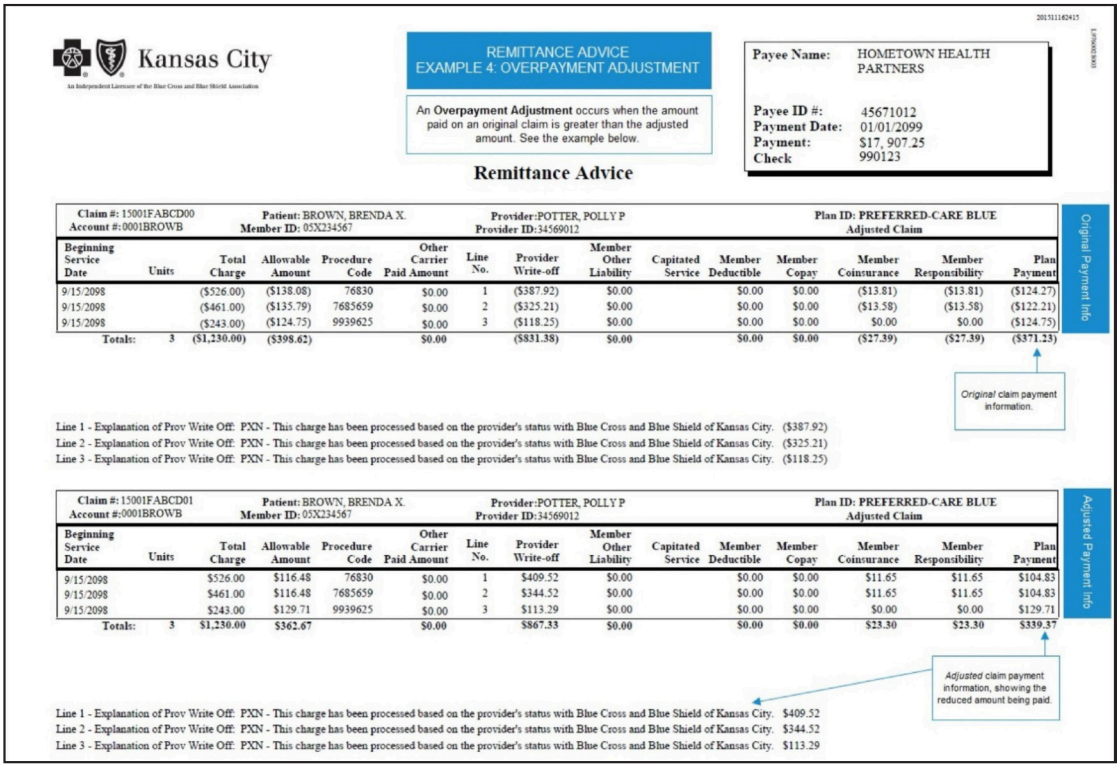
Adjusted Payment Info

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
12/28/2098		$466.00	$163.21	76805	$0.00	1	$302.79	$0.00		$0.00	$0.00	$0.00	$0.00	$163.21
Totals:	1	$466.00	$163.21		$0.00		$302.79	$0.00		$0.00	$0.00	$0.00	$0.00	$163.21

Adjusted claim payment information, showing the additional amount being paid.

Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $302.79
Other Information:
Adjustment request will be processed on original claim.

Example 4 – Overpayment Adjustment



Kansas City

REMITTANCE ADVICE
EXAMPLE 4: OVERPAYMENT ADJUSTMENT

An **Overpayment Adjustment** occurs when the amount paid on an original claim is greater than the adjusted amount. See the example below.

Payee Name: HOMETOWN HEALTH PARTNERS

Payee ID #: 45671012
Payment Date: 01/01/2099
Payment: $17,907.25
Check 990123

Remittance Advice

Claim #: 15001FABCD00 Account #:0001BROWB | Patient: BROWN, BRENDA X. Member ID: 05X234567 | Provider: POTTER, POLLY P Provider ID: 34569012 | Plan ID: PREFERRED-CARE BLUE Adjusted Claim

Original Payment Info

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
9/15/2098		($526.00)	($138.08)	76830	$0.00	1	($387.92)	$0.00		$0.00	$0.00	($13.81)	($13.81)	($124.27)
9/15/2098		($461.00)	($135.79)	7685659	$0.00	2	($325.21)	$0.00		$0.00	$0.00	($13.58)	($13.58)	($122.21)
9/15/2098		($243.00)	($124.75)	9939625	$0.00	3	($118.25)	$0.00		$0.00	$0.00	$0.00	$0.00	($124.75)
Totals:	3	($1,230.00)	($398.62)		$0.00		($831.38)	$0.00		$0.00	$0.00	($27.39)	($27.39)	($371.23)

Original claim payment information.

Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. ($387.92)
Line 2 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. ($325.21)
Line 3 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. ($118.25)

Claim #: 15001FABCD01 Account #:0001BROWB | Patient: BROWN, BRENDA X. Member ID: 05X234567 | Provider: POTTER, POLLY P Provider ID: 34569012 | Plan ID: PREFERRED-CARE BLUE Adjusted Claim

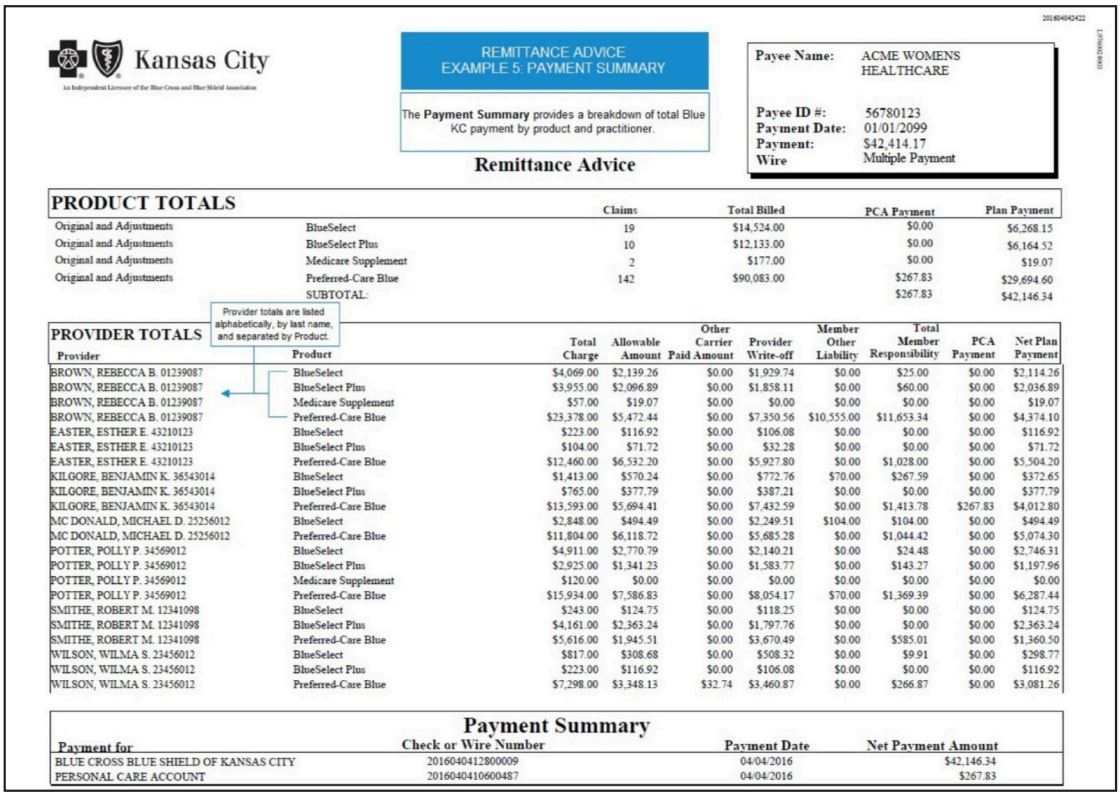
Adjusted Payment Info

Beginning Service Date	Units	Total Charge	Allowable Amount	Procedure Code	Other Carrier Paid Amount	Line No.	Provider Write-off	Member Other Liability	Capitated Service	Member Deductible	Member Copay	Member Coinsurance	Member Responsibility	Plan Payment
9/15/2098		$526.00	$116.48	76830	$0.00	1	$409.52	$0.00		$0.00	$0.00	$11.65	$11.65	$104.83
9/15/2098		$461.00	$116.48	7685659	$0.00	2	$344.52	$0.00		$0.00	$0.00	$11.65	$11.65	$104.83
9/15/2098		$243.00	$129.71	9939625	$0.00	3	$113.29	$0.00		$0.00	$0.00	$0.00	$0.00	$129.71
Totals:	3	$1,230.00	$362.67		$0.00		$867.33	$0.00		$0.00	$0.00	$23.30	$23.30	$339.37

Adjusted claim payment information, showing the reduced amount being paid.

Line 1 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $409.52
Line 2 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $344.52
Line 3 - Explanation of Prov Write Off: PXN - This charge has been processed based on the provider's status with Blue Cross and Blue Shield of Kansas City. $113.29

Example 5 – Payment Summary



Kansas City

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REMITTANCE ADVICE
EXAMPLE 5: PAYMENT SUMMARY

The **Payment Summary** provides a breakdown of total Blue KC payment by product and practitioner.

Remittance Advice

Payee Name:	ACME WOMENS HEALTHCARE
Payee ID #:	56780123
Payment Date:	01/01/2099
Payment:	$42,414.17
Wire	Multiple Payment

PRODUCT TOTALS

		Claims	Total Billed	PCA Payment	Plan Payment
Original and Adjustments	BlueSelect	19	$14,524.00	$0.00	$6,268.15
Original and Adjustments	BlueSelect Plus	10	$12,133.00	$0.00	$6,164.52
Original and Adjustments	Medicare Supplement	2	$177.00	$0.00	$19.07
Original and Adjustments	Preferred-Care Blue	142	$90,083.00	$267.83	$29,694.60
	SUBTOTAL:			$267.83	$42,146.34

Provider totals are listed alphabetically, by last name, and separated by Product.

PROVIDER TOTALS

Provider	Product	Total Charge	Allowable Amount	Other Carrier Paid Amount	Provider Write-off	Member Other Liability	Total Member Responsibility	PCA Payment	Net Plan Payment
BROWN, REBECCA B. 01239087	BlueSelect	$4,069.00	$2,139.26	$0.00	$1,929.74	$0.00	$25.00	$0.00	$2,114.26
BROWN, REBECCA B. 01239087	BlueSelect Plus	$3,955.00	$2,096.89	$0.00	$1,858.11	$0.00	$60.00	$0.00	$2,036.89
BROWN, REBECCA B. 01239087	Medicare Supplement	$57.00	$19.07	$0.00	$0.00	$0.00	$0.00	$0.00	$19.07
BROWN, REBECCA B. 01239087	Preferred-Care Blue	$23,378.00	$5,472.44	$0.00	$7,350.56	$10,555.00	$11,653.34	$0.00	$4,374.10
EASTER, ESTHER E. 43210123	BlueSelect	$223.00	$116.92	$0.00	$106.08	$0.00	$0.00	$0.00	$116.92
EASTER, ESTHER E. 43210123	BlueSelect Plus	$104.00	$71.72	$0.00	$32.28	$0.00	$0.00	$0.00	$71.72
EASTER, ESTHER E. 43210123	Preferred-Care Blue	$12,460.00	$6,532.20	$0.00	$5,927.80	$0.00	$1,028.00	$0.00	$5,504.20
KILGORE, BENJAMIN K. 36543014	BlueSelect	$1,413.00	$570.24	$0.00	$772.76	$70.00	$267.59	$0.00	$372.65
KILGORE, BENJAMIN K. 36543014	BlueSelect Plus	$765.00	$377.79	$0.00	$387.21	$0.00	$0.00	$0.00	$377.79
KILGORE, BENJAMIN K. 36543014	Preferred-Care Blue	$13,593.00	$5,694.41	$0.00	$7,432.59	$0.00	$1,413.78	$267.83	$4,012.80
MC DONALD, MICHAEL D. 25256012	BlueSelect	$2,848.00	$494.49	$0.00	$2,249.51	$104.00	$104.00	$0.00	$494.49
MC DONALD, MICHAEL D. 25256012	Preferred-Care Blue	$11,804.00	$6,118.72	$0.00	$5,685.28	$0.00	$1,044.42	$0.00	$5,074.30
POTTER, POLLY P. 34569012	BlueSelect	$4,911.00	$2,770.79	$0.00	$2,140.21	$0.00	$24.48	$0.00	$2,746.31
POTTER, POLLY P. 34569012	BlueSelect Plus	$2,925.00	$1,341.23	$0.00	$1,583.77	$0.00	$143.27	$0.00	$1,197.96
POTTER, POLLY P. 34569012	Medicare Supplement	$120.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
POTTER, POLLY P. 34569012	Preferred-Care Blue	$15,934.00	$7,586.83	$0.00	$8,054.17	$70.00	$1,369.39	$0.00	$6,287.44
SMITHE, ROBERT M. 12341098	BlueSelect	$243.00	$124.75	$0.00	$118.25	$0.00	$0.00	$0.00	$124.75
SMITHE, ROBERT M. 12341098	BlueSelect Plus	$4,161.00	$2,363.24	$0.00	$1,797.76	$0.00	$0.00	$0.00	$2,363.24
SMITHE, ROBERT M. 12341098	Preferred-Care Blue	$5,616.00	$1,945.51	$0.00	$3,670.49	$0.00	$585.01	$0.00	$1,360.50
WILSON, WILMA S. 23456012	BlueSelect	$817.00	$308.68	$0.00	$508.32	$0.00	$9.91	$0.00	$298.77
WILSON, WILMA S. 23456012	BlueSelect Plus	$223.00	$116.92	$0.00	$106.08	$0.00	$0.00	$0.00	$116.92
WILSON, WILMA S. 23456012	Preferred-Care Blue	$7,298.00	$3,348.13	$32.74	$3,460.87	$0.00	$266.87	$0.00	$3,081.26

Payment Summary

Payment for	Check or Wire Number	Payment Date	Net Payment Amount
BLUE CROSS BLUE SHIELD OF KANSAS CITY	2016040412800009	04/04/2016	$42,146.34
PERSONAL CARE ACCOUNT	2016040410600487	04/04/2016	$267.83

The examples on the previous pages represent the format of the Professional Provider Remittance Advice. The Facility Remittance Advice is slightly different.

Kansas City

BLUE KC NETWORK PROVIDER REFERENCE GUIDE

A reference manual for all Blue KC contracted network providers.

D/25074_4/25