

Recoupment Process for Blue EssentialsSM, Blue PremierSM and Blue Advantage HMOSM

The "Refund Policy for Blue Essentials, Blue Premier and Blue Advantage HMO" states that Blue Essentials, Blue Premier, and Blue Advantage HMO has 180 days following the payee's receipt of an overpayment to notify a Physician or Provider that the overpayment has been identified and to request a refund.* For additional information on the Blue Essentials, Blue Premier and Blue Advantage HMO Refund Policy, including when a Physician or Provider may submit a claim review and when an overpayment may be placed into recoupment status, please refer to the "Refund Policy" in Section F in the Blue Essentials, Blue Premier and Blue Advantage HMO Physician, Professional Providers, Facility and Ancillary Provider Manual or go back to the Recoupments/Refunds section on the BCBSTX provider website.

In some unique circumstances a Physician or Provider may request, in writing, that **Blue Essentials, Blue Premier or Blue Advantage HMO** review all claims processed during a specified period; in this instance all underpayments and overpayments will be addressed on a claim-by-claim basis.

- * Note: The refund request letter may be sent at a later date when the claim relates to Blue Essentials, Blue Premier or Blue Advantage HMO accounts and transactions that are excluded from the requirements of the Texas Insurance Code and other provisions relating to the prompt payment of claims, including:
 - Self-funded ERISA (Employee Retirement Income Security Act)
 - Indemnity Plans
 - Medicaid, Medicare and Medicare Supplement
 - Federal Employees Health Benefit Plan
 - Self-funded governmental, school and church health plans
 - Out-of-state Blue Cross and Blue Shield plans (BlueCard)
 - Out-of-network (non-participating) providers

Recoupment Process

Blue Essentials, Blue Premier and Blue Advantage HMO

When a Physician's or Provider's overpayment is placed into a recoupment status, the claims system will automatically off-set future claims payment and generate a Provider Claims Summary (PCS) to the Physician or Provider (Recoupment Process). The PCS will indicate a recouped line along with information concerning the overpayment of the applicable **Blue Essentials**, **Blue Premier or Blue Advantage HMO** claim(s).

To view an example of a recoupment, please refer to the sample PCS on page 2 below or go to Section F in the Blue Essentials (formerly known as HMO Blue Texas), Blue Premier and Blue Advantage HMO Physician, Professional Providers, Facility and Ancillary Provider Manual.

For additional information or if you have questions regarding the Blue Essentials or Blue Advantage HMO Recoupment Process, please contact **800-451-0287** to speak with an **Blue Essentials, Blue Premier or Blue Advantage HMO** Customer Advocate.

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Sample PCS Recoupment

DATE:

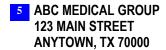
MM/DD/YY

PROVIDER NUMBER:

0001112222 123456789

CHECK NUMBER: TAX IDENTIFICATION NUMBER:

987654321



ANY MESSAGES WILL APPEAR ON PAGE 1

PATIENT: PERF PRV:

CLAIM NO:

JOHN DOE

1234567890 00001234567890C **IDENTIFICATION NO:** PATIENT NO:

P06666-XOC123456789

12345KB

11 FROM/TO DATES 02/09 - 02/09/12

13 PS* PAY

14 **PROC** CODE

15 **AMOUNT BILLED**

ALLOWABLE **AMOUNT**

SERVICES NOT COVERED (1) 25.48

DEDUCTIONS/ **OTHER INELIGIBLE**

19 **AMOUNT** PAID

03 **HMO** 99213

76.00 76.00

50.52 50.52

25.48

0.00 0.00

50.52 50.52

²⁰ AMOUNT PAID TO PROVIDER FOR THIS CLAIM:

DEDUCTIONS/OTHER INELIGIBLE

\$50.52

25.48

TOTAL SERVICES NOT COVERED:

PROVIDER CLAIMS AMOUNT SUMMARY

PATIENT'S SHARE:

0.00

23

NUMBER OF CLAIMS:

1 \$76.00 AMOUNT BILLED: AMOUNT OVER MAXIMUM \$25.48

ALLOWANCE:

AMOUNT OF SERVICES NOT \$25.48

COVERED:

AMOUNT PREVIOUSLY PAID:

\$0.00

NET AMOUNT PAID TO PROVIDER:

AMOUNT PAID TO SUBSCRIBER:

AMOUNT PAID TO PROVIDER:

RECOUPMENT AMOUNT:

\$19.00

\$0.00

\$50.52

\$31.52

* PLACE OF SERVICE (PS) PHYSICIAN'S OFFICE.

25 MESSAGES:

03

(1). CHARGE EXCEEDS THE PRICED AMOUNT FOR THIS SERVICE. SERVICE PROVIDED BY A PARTICIPATING PROVIDER. PATIENT IS NOT RESPONSIBLE FOR CHARGES OVER THE PRICED AMOUNT.

Continued on next page

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Professional Provider Claim Summary Field Explanations

1_	Date	Date the summary was finalized
2	Provider Number	Provider's NPI
3	Check Number	The number assigned to the check for this
		summary
4	Tax Identification Number	The number that identifies your taxable
		income
5	Provider or Group Name and	Address of the provider/group who
	Address	rendered the services
6	Patient	The name of the individual who received
		the service
7	Performing Provider	The number that identifies the provider that
		performed the services
8	Claim Number	The Blue Shield number assigned to the
		claim
9	Identification Number	The number that identifies the group and
		member insured by BCBSNM
10	Patient Number	The patient's account number assigned by
4.4		the provider
11	From/To Dates	The beginning and ending dates of services
12	PS PAY	Place of service
13	PAY	Reimbursement payment rate that was
		applied in relationship to the member's
14	Procedure Code	policy type
14	Procedure Code	The code that identifies the procedure performed
15	Amount Billed	The amount billed for each
15	Amount Billed	procedure/service
16	Allowable Amount	The highest amount BCBSNM will pay for
		a specific type of medical procedure.
4=		
17	Services Not Covered	Non-covered services according to the
18	Doductions/Other Inclinible	member's contract
10	Deductions/Other Ineligible	Program deductions, copayments, and coinsurance amounts
19	Amount Paid	The amount paid for each
19		procedure/service
20	Amount Paid to Provider for	The amount Blue Shield paid to provider for
	This Claim	this claim
21	Total Services Not Covered	Total amount of non-covered services for
		the claim
22	Patient's Share	Amount patient pays. Providers may bill this
		amount to the patient.
23	Provider Claims Amount	How all of the claims on the PCS were
	Summary	adjudicated
24	Place of Service (PS)	The description for the place of service
		code used in field 12
25	Messages	The description for messages relating to:
		non-covered services, program deductions,
		and PPO reductions

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