

Filing Claims

Direct and Timely Billing

As a Regence BlueShield of Idaho participating physician, other health care professional or facility, you have agreed to bill us directly for covered services provided to your Regence BlueShield of Idaho or Regence Life and Health patients within one year of the date of service. Once coverage is verified, patients should not be asked for full payment at the time of service, although asking for copayments, coinsurance and deductibles are appropriate. After services are rendered, the patient should only be billed for any remaining deductible, copayment and/or coinsurance amounts not collected and non-covered services.

Timely Filing Guidelines

Regence BlueShield of Idaho requires that all eligible claims for covered services performed be received by Regence BlueShield of Idaho no later than 12 months from the date that services were rendered. Claims which are not reported or which are not filed timely will not be paid and the participating physician, other health care professional or facility agrees not to bill the member or Regence BlueShield of Idaho for services associated with such claims.

If a payment voucher is not received within 45 days of submission of the claim, the physician or other health care professional should verify via Regence Online Services for Providers that the claim was received. Lack of follow-up may result in the claim being denied for timely filing. When submitting a claim electronically, it is important to check the error report to verify that a claim has been successfully sent.

All information required to process a claim must be submitted in a timely manner (i.e., date of onset, accident information, medical records as requested).

Alpha Prefix

Regence BlueShield of Idaho members have an alpha prefix that appears on their member card. Always include the alpha prefix when billing Regence BlueShield of Idaho. The alpha prefix gives members the ability to travel outside of their home plan service area and take advantage of the Blue Shield and/or Blue Cross physician, other health care professional and facility networks nationwide. For more information, please see the BlueCard section of this manual.

Use Your Identification Number

All electronically submitted claims must include the National Provider Identifier (NPI) along with the required tax identification number. Until further notice an electronically submitted claim may also include the appropriate Regence BlueShield of Idaho provider identification number.

The NPI is not required for paper claim submissions, though we strongly recommend you apply for and use an NPI. Paper claim submissions can continue to be submitted using the Regence BlueShield of Idaho provider identifier with or without an NPI. If you are unsure of your provider identification number, please contact your local provider consultant.

Filing Claims Electronically

Electronic billing through Availity L.L.C. or Office Ally is available for all Regence BlueShield of Idaho, Regence Life and Health and BlueCard® out-of-area claims.

Electronic claims submission offers the following advantages:

- Single submission point for all electronic claims
- Faster claims turnaround time
- Automated claims payment for clean claims
- Detailed online submission and error reports
- Online real-time editing
- No per-claim submission charge for Regence claims to if you submit directly through Availity L.L.C. or Office Ally.

If you already submit claims electronically, the following reminders are for you:

- Always enter the patient's information exactly as it appears on their member card. This will help avoid misrouting and processing delays.
- Use your online reports to help research claims processing.
- All claims for out-of-area members with alpha prefixes can and should be billed electronically to expedite their processing.
- Only claims for Medicare adjustments should be billed on paper.

To find out more about submitting claims electronically through Availity LLC contact their EDI Support Center by phone at 1(800) 282-4548. For information about submitting claims through Office Ally contact them via email at info@officeally.com or by phone at (949) 464-9129.

File rejection reports

If you need help with an electronic rejection report that is not from Availity or your clearinghouse, contact Regence EDI Support Center 1 (800) 713-1693 or email EDIsupport@regence.com.

Electronic Funds Transfer

Regence offers participating providers the option of having their funds deposited directly into their bank account. If you are interested in beginning this process or have any questions, please contact Customer Service at 1 (800) 632-2022, or complete an Authorization Agreement for Automatic Deposits (ACH Credits) form, available on our *Provider Web Site*.

Filing Claims Manually

Acceptable Claim Forms

Regence requires paper claims to be submitted on an original, standard *CMS 1500 (8/05)* or *UB-04* claim form. Instructions for completing these forms begin on the next page and are followed by samples of each form. Once received, paper claims are scanned and converted into electronic images that are viewed and processed online by our claims analysts. Incomplete claim forms may be returned for missing information. Please observe the following guidelines to ensure your claims are successfully imaged:

- Key or type all information onto your claims. Handwriting and stamps are not always dark or legible enough to be captured by our imaging equipment. Centers for Medicare & Medicaid Services (CMS) no longer accept signature stamps.
- Do not use highlighters on your claims. The imaging equipment 'blacks out' the portions of your claims that are highlighted, making the information unreadable.

Where to Send Original Paper Claims

The mailing address for filing all paper claims except Federal Employee Program (FEP) is:

Regence BlueShield of Idaho
P.O. Box 31603
Salt Lake City, UT 84131-0603

For FEP claims submitted by professional providers south of Idaho County and all facilities:

BlueCross of Idaho
P.O. Box 7408
Boise, ID 83707

For FEP claims submitted by professional providers in Idaho County and north:
Regence BlueShield of Idaho FEP Claims
P.O. Box 30270
Salt Lake City, UT 84131

Coordination of Benefit Information

Coordination of Benefits (COB) is a system which permits your patients to receive benefits from all health insurance plans under which they have coverage while assuring that the total, combined payment from the plans is not more than the total allowed for the service.

When your patient has coverage under two or more insurance plans, one plan is considered the primary plan and “pays first.” The other plan is considered the secondary plan and pays any balances remaining up to its coverage limits. The combined payments provided by the primary and secondary plans cannot be more than the total charges.

Regence BlueShield of Idaho determines primary/secondary payer according to the National Association of Insurance Commissioners (NAIC) guidelines and any applicable Idaho law or regulation.

Workers’ Compensation statutes provide that Workers’ Compensation insurance is primary coverage for all job-related injury or illness claims. These claims should be sent to the patient’s Workers’ Compensation carrier, not to Regence BlueShield of Idaho. The general rule in coordination of benefits is that payment is based on the highest allowed amount between the primary and secondary insurers.

Submitting your Claims

If your patient has two coverages and Regence BlueShield of Idaho’s coverage is secondary, please submit a copy of the primary insurance carrier’s explanation of benefits, along with a complete itemized statement.

If your patient is covered by two group benefit contracts through Regence BlueShield of Idaho, be sure to list both of the group and identification numbers on the claim. We will then process the primary plan first and any remaining balances will be considered for payment under the secondary plan. It is not necessary to send in two separate claims.

Maintenance of Benefits

A method of comparing benefits payable under more than one insurance plan to ensure that no plan benefits are paid on the secondary insurance plan if the primary insurance benefits are equal or greater than the secondary plan benefits.

Other Party Liability

Other Party Liability (OPL) is a cost containment program that recovers money where primary responsibility does not exist because of another group health plan or contractual exclusions. OPL includes worker's compensation, subrogation and no-fault auto insurance.

In cases where another Blue Plan is involved as the third party, submit OPL information with the Blue Plan claim to Regence BlueShield of Idaho. Upon receipt, Regence BlueShield of Idaho will electronically route the claim to the member's Blue Plan. The member's Blue Plan will then process the claim and approve any payment based on the member's benefits. Regence BlueShield of Idaho will reimburse you accordingly and provide information on your payment voucher.

Third-Party Liability

If a member is injured through the actions of a third party and is entitled to recovery from the third party for medical expenses, the member is obligated to reimburse Regence BlueShield of Idaho for the reasonable value of the medical services received as a result of their injury. Their Regence BlueShield of Idaho plan will coordinate benefits when a member is entitled to Workers' Compensation, automobile medical, no-fault liability insurance policy or an employer group health plan.

If automobile medical or no-fault insurance is available to a member, then benefits under that plan must be used first. Their Regence BlueShield of Idaho plan will pay only as secondary payer of benefits regardless of whether or not a claim is made to the primary payer.

Payments of funds may be made directly between members and other providers of benefits. If benefits are provided in the form of service rather than cash payments, the reasonable cash value of each service rendered should be deemed both an allowable expense and a benefit paid.

None of the rules pertaining to coordination of benefits will serve as a barrier to the member first receiving covered services from Regence BlueShield of Idaho physicians or other health care professionals.

The member must notify his/her plan when there is a possibility that a third party may be liable for the injuries. Their plan will have a first-party lien against such accident-related settlements, even if the settlement does not specifically include payment for medical costs. Upon settlement, their plan will be reimbursed at the prevailing rates for the cost of services and benefits provided as a result of the injury. In the event the third party makes a payment to the member instead of the Regence BlueShield of Idaho plan, the member must agree to reimburse their plan for any payments received from the third party in connection with treatment of the injury or any complications. The member need only reimburse their plan up to the amount of the recovery.

The member must agree to cooperate in protecting the interests of their Regence BlueShield of Idaho plan under the health care plan provisions and to execute and deliver to their Regence BlueShield of Idaho plan, or its nominee, any and all assignments or other documents which may be necessary or proper to fully and completely carry out and protect the rights of the Regence BlueShield of Idaho plan or its nominee.

Medicare Crossover claims

If you accept Medicare assignment and render services to members from other Blue Plans, please note the following.

Medicare is primary: When Medicare is the primary payer for an out-of-area Blue Plan member (e.g., Medigap plans), follow these procedures:

1. Submit claims to your local Medicare contractor first. **Do not file with Medicare and the supplemental insurer simultaneously.** Be sure to include the:
 - Complete Health Insurance Claim Number (HICN),
 - The patient's complete member number, and
 - Patient's name as it appears on the card
 - Other carrier's name and address (OCNA) number. If you include this information, make sure it is the correct OCNA for the member's Blue Plan.
2. After you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare, determine if the claim was automatically crossed over to the supplemental insurer:
 - **Crossed over:** If the indicator on the EOMB or payment advice shows that the claim was crossed-over (claim status code 19: "Medicare paid primary and the Intermediary sent the claim to another insurer"), Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. You do not need to file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you, if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.
 - **Not crossed over:** If the indicator on the EOMB or payment advice does not indicate the claim was crossed over (claim status code 1: "Paid as primary" may appear; claim status 19 will not appear), file the claim as you do today to Regence BlueShield of Idaho along with the payment advice. Regence BlueShield of Idaho or the member's Blue Plan will pay you the Medicare supplemental benefits. If you did not accept Medicare assignment, the member will be paid and you will need to bill the member.

Blue Plan is primary: When a Blue Plan is the primary payer (e.g., Medicare Advantage), submit claims to Regence BlueShield of Idaho. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Based on the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a physician, other health care professional or facility who accepts Medicare assignment and renders service to Medicare Advantage members from other Blue Plans, you will be reimbursed the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than your charge amount. CMS regulations state that the Medicare allowable amount is considered payment in full.

Note: Medicare Advantage Private Fee for Service (PFFS) reimbursement is paid at the Home plan contracted rate or Medicare rate, depending on the member contract.

Other than the applicable member cost sharing amounts, reimbursement is made directly by the Blue Plan. You may collect only the applicable cost sharing (i.e., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill.

CMS 1500 Claim Form Instructions

To complete this form, follow the instructions below. **Each field on the form has a corresponding number. Claims submitted with missing or invalid required fields may be rejected and/or returned for correction and resubmission.**

Requirements	Field	Description
	1:	Type of Health Insurance Show the type of health insurance coverage applicable to this claim by checking the appropriate box.
Required	1A:	Insured's Identification Number Enter the three-digit alpha prefix and identification number of the insured <i>exactly as shown on the member card</i> .
Required	2:	Patient's Name Enter the last name, first name, and middle initial (if known) of the patient exactly as shown on the member card. <i>Do not use nicknames.</i>
Required	3:	Patient's Birth Date and Sex Enter the eight-digit month, day, century, and year of the patient's birth (MMDDCCYY). Check the appropriate box to identify patient's gender.
Required	4:	Insured's Name Enter the last name, first name, and middle initial of the insured as shown on the member card. If the patient is the insured, enter the word "same".
Required	5:	Patient's Address Enter the patient's complete address.
Required	6:	Patient's Relationship to Insured Check self, spouse, child or other.
	7:	Insured's Address Complete if the patient <i>is not</i> the insured.
	8:	Patient Status Check the appropriate box.
Recommended	9:	Other Insured's Name Enter the name of the insured with other insurance company.
Recommended	9A:	Other Insured's Policy or Group Number Enter the policy and/or group number of the other insurance coverage.

Recommended	9B:	Other Insured's Date of Birth Enter the information available to you in eight-digit format (MMDDCCYY).
	9C:	Employer's Name or School Name Enter the complete name.
	9D:	Insurance Plan Name or Program Name Enter the name of the insurance plan.
Required	10:	Is Patient's Condition Related to Check the correct boxes in a., b. and c.
	10D:	Reserved for Local Use Leave blank.
Required	11:	Insured's Policy or FECA Number Enter the group number of the insured as shown on the member card. Exception: If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
Recommended	11A:	Insured's Date of Birth Use eight-digit date format if submitting.
	11B:	Employer's Name or School Name
	11C:	Insurance Plan Name or Program Name
	11D:	Additional Benefit Plans
	12:	Patient's or Authorized Person's Signature Have patient sign if your office requires it.
	13:	Insured's or Authorized Person's Signature May be left blank.
Required for accidents or injuries Recommended for all other	14:	Date of Current illness, Injury, Pregnancy Enter the date of the current illness, injury or pregnancy.

	15:	If Patient has had Same or Similar illness Enter the date the patient first consulted you for this condition.
	16:	Dates Patient Unable to Work in Current Occupation Leave blank.
	17:	Name of Referring Provider or Other Source List the name of the referring, ordering or supervising physician or other health care professional.
	17A:	Other ID # Enter the assigned Regence provider number if submitting a paper claim and the physician or other health care professional listed in field 17.
	17B:	NPI # Enter the assigned NPI of the physician or other health care professional listed in field 17 for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
Recommended	18:	Hospitalization Dates Related to Current Services
	19:	Reserved for Local Use Leave blank.
	20:	Outside Lab If your patient had lab work done, check the correct box <i>even if you are not billing for the lab work</i> . Do not list charges in this field.
Required	21:	Diagnosis or Nature of illness or Injury Identify the patient's condition(s) by entering up to four ICD-9-CM codes in order of relevance. Codes must be carried out to the highest possible (4th or 5th) digit. Non-specific diagnoses, such as 780, may result in denials.
	22:	Medicaid Resubmission Leave blank.
	23:	Prior Authorization Number Leave blank.

Required	24A:	Date(s) of Service Enter the date(s) of service. If only one service is provided, the date can be entered as a “from date” or a “to date”.
Required	24B:	Place of Services Indicate where services were provided by entering the appropriate two-digit place of service code. Valid codes are as follows: 11 Office 12 Home 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room 24 Ambulatory Surgery Center 25 Birthing Center 26 Military Treatment Center 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance (land) 42 Ambulance (air or water) 51 Inpatient Psychiatric Facility 52 Psychiatric Facility Partial Hospitalization 53 Community Mental Health Facility 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility
	24C:	Emergency Indicator (EMG) Leave blank.
Required	24D:	Procedures, Services, or Supplies: CPT/HCPCS, Modifier Enter a valid procedure code best describing each service or supply. Explain unusual services or situations with procedure code modifiers. If a CPT and a HCPCS code describe the same service, use the CPT code. Claims with an invalid or missing procedure code may be denied or returned for correction and resubmission.
Required	24E:	Diagnosis Pointer Enter one diagnosis code reference number per claim line (i.e., up to four ICD-9-CM codes) as shown in item 21, to relate the date of service and the procedures performed to the appropriate diagnosis.
Required	24F:	Charges

		Enter your charge for each listed service.
Required	24G:	Days or Units Enter the number of services billed on the line. For anesthesia services, report time and modifier units on separate lines.
	24H:	EPSDT Family Plan Leave blank.
Required if applicable	24I:	ID Qualifier If entering an individual Regence provider number in 24J, ID Qualifier Code '1B' is required.
Required if applicable	24J:	Rendering Provider ID # (split field) The individual performing/rendering the service. The rendering provider ID # is required when different than the billing provider found in Field 33. Please submit only one provider per claim. Unlabeled Field – Enter your individual Regence provider number if submitting paper claim. NPI Field – Enter your Type 1 individual NPI number for electronic claims submission. If submitting a paper claim the NPI may be included, if known.
Required	25:	Federal Tax ID Number Enter the provider's tax identification number as given by the Internal Revenue Service.
Recommended	26:	Patient's Account Number If you use patient account numbers, enter the number for this patient.
Required for Medicare only	27:	Accept Assignment Please check applicable box.
Required	28:	Total Charge Enter the total of all charges submitted on this claim.
Recommended	29:	Amount Paid Enter the exact amount the patient and/or other insurance carrier has paid to you for these services. Entering the words 'patient paid' without indicating the exact amount may cause claims delays and inaccurate processing.
	30:	Balance Due Enter the difference between Field 28 and Field 29.
Required	31:	Signature of Physician or Supplier

		Sign and date the form. Stamped and preprinted signatures that include the degree are acceptable for all products except Regence MedAdvantage. Claims for this product must be signed or have a preprinted signature including degree.
Required if applicable	32:	Service Facility Location Information Enter name and address of the location where the services were rendered.
Required if applicable	32A:	NPI # Enter the service facility NPI number (Type 2) of the service facility location, if known.
Required if applicable	32B:	Other ID Enter the two digit ID qualifier '1B' and the service facility Regence provider number of the service facility location if submitting a paper claim.
Required	33:	Billing Provider Information and Phone # Enter the billing provider's name, address, zip code, and telephone number.
Required for electronic claim submissions	33A:	NPI # Enter the NPI number (Type 1 or 2) of the billing provider. The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
Required for paper claims submissions if not submitting an NPI	33B:	Other ID Enter the two digit ID qualifier '1B' and the Regence provider number of the billing provider. Other ID is required if submitting a paper claim and 33A does not include an NPI.

Instructions to complete a paper UB-04

All hospitals participating with Regence are required to submit UB-04 claims in electronic format. Following are instructions for completing a paper UB-04 claim.

Requirements	Form Locator	Description																																														
Required	1:	Provider Name and Address, and Telephone Number Enter provider's name, address, zip code and phone number.																																														
	2:	Pay-to Name, Address, and Secondary Identification Fields Leave blank.																																														
Required	3:	Patient Control Number Enter patient's control number or patient account number.																																														
Required	4:	<p>Type of Bill (TOB) Enter type of bill code.</p> <p>Valid type of bill codes:</p> <table> <tr> <td>Hospital – Inpatient</td> <td>11X</td> <td>12X</td> <td>18X</td> </tr> <tr> <td>Hospital – Outpatient</td> <td>13X</td> <td>14X</td> <td></td> </tr> <tr> <td>Skilled Nursing – Inpatient</td> <td>21X</td> <td>22X</td> <td></td> </tr> <tr> <td>Skilled Nursing – Outpatient</td> <td>23X</td> <td></td> <td></td> </tr> <tr> <td>Home Health</td> <td>32X</td> <td>33X</td> <td>34X</td> </tr> <tr> <td>Clinic</td> <td>71X</td> <td>72X</td> <td>73X 74X 75X</td> </tr> <tr> <td></td> <td>76X</td> <td>79X</td> <td></td> </tr> <tr> <td>Special Facility</td> <td>81X</td> <td>82X</td> <td>83X 85X</td> </tr> </table> <p>Valid third digit codes:</p> <table> <tr> <td>Admit through discharge claim</td> <td>1</td> </tr> <tr> <td>Interim - First claim</td> <td>2</td> </tr> <tr> <td>Interim - Continuing claim</td> <td>3</td> </tr> <tr> <td>Interim - Last claim</td> <td>4</td> </tr> <tr> <td>Late charges only claim</td> <td>5</td> </tr> <tr> <td>Replacement of prior claim</td> <td>7</td> </tr> <tr> <td>Void/cancel prior claim</td> <td>8</td> </tr> </table>	Hospital – Inpatient	11X	12X	18X	Hospital – Outpatient	13X	14X		Skilled Nursing – Inpatient	21X	22X		Skilled Nursing – Outpatient	23X			Home Health	32X	33X	34X	Clinic	71X	72X	73X 74X 75X		76X	79X		Special Facility	81X	82X	83X 85X	Admit through discharge claim	1	Interim - First claim	2	Interim - Continuing claim	3	Interim - Last claim	4	Late charges only claim	5	Replacement of prior claim	7	Void/cancel prior claim	8
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Interim - Continuing claim	3																																															
Interim - Last claim	4																																															
Late charges only claim	5																																															
Replacement of prior claim	7																																															
Void/cancel prior claim	8																																															
Required	5:	Federal Tax Number Enter your federal tax identification number.																																														
Required	6:	Statement Covers Period (From-Through) Enter statement covers from and through date. Must be in MMDDYY format.																																														

	7:	Untitled Not used
Required	8:	Patient's Name Enter patient's last name, first name and middle initial.
Required	9:	Patient Address Enter patient's full mailing address including street number, city, state and zip code.
Required	10:	Patient Birth Date Enter patient's date of birth. Must be in MMDDCCYY format.
Required	11:	Patient Sex Enter "M" (male) or "F" (female).
Required	12:	Admission Date Enter date patient is admitted for this stay. Must be in MMDDYY format.
Required for inpatient claims	13:	Admission Hour Enter the admission hour code. Valid Admission Hour Codes. 00 = 12:00-12:59 midnight 12 = 12:00-12:59 noon 01 = 01:00-01:59 13 = 01:00-01:59 02 = 02:00-02:59 14 = 02:00-02:59 03 = 03:00-03:59 15 = 03:00-03:59 04 = 04:00-04:59 16 = 04:00-04:59 05 = 05:00-05:59 17 = 05:00-05:59 06 = 06:00-06:59 18 = 06:00-06:59 07 = 07:00-07:59 19 = 07:00-07:59 08 = 08:00-08:59 20 = 08:00-08:59 09 = 09:00-09:59 21 = 09:00-09:59 10 = 10:00-10:59 22 = 10:00-10:59 11 = 11:00-11:59 23 = 11:00-11:59 99 = Unknown
Required for inpatient claims	14:	Type of Admission/Visit Enter the type of admission code. This code indicates the priority of this admission. Valid type of admission codes: 1 = Emergency 2 = Urgent

		<p>3 = Elective 4 = Newborn 5 = Trauma Center 9 = Information not available</p>
Required	15:	<p>Point of Origin for Admission or Visit Enter the code indicating the source of the referral for this admission or visit.</p> <p>Valid source of admission codes: 1 = Non-Health Care Facility 2 = Clinic 3 = Reserved for national assignment 4 = Transfer from a hospital (different facility) 5 = Transfer from a skilled nursing facility or Intermediate Care Facility 6 = Transfer from another health care facility 7 = Emergency Room 8 = Court/Law enforcement 9 = Information not available B = Transfer from another home health agency C = Readmission to same home health agency D = Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer E = Transfer from ambulatory surgery center</p>
Required for inpatient claims	16:	<p>Discharge Hour Enter the discharge hour code.</p> <p>Valid Discharge Hour Codes. 00 = 12:00-12:59 midnight 12 = 12:00-12:59 noon 01 = 01:00-01:59 13 = 01:00-01:59 02 = 02:00-02:59 14 = 02:00-02:59 03 = 03:00-03:59 15 = 03:00-03:59 04 = 04:00-04:59 16 = 04:00-04:59 05 = 05:00-05:59 17 = 05:00-05:59 06 = 06:00-06:59 18 = 06:00-06:59 07 = 07:00-07:59 19 = 07:00-07:59 08 = 08:00-08:59 20 = 08:00-08:59 09 = 09:00-09:59 21 = 09:00-09:59 10 = 10:00-10:59 22 = 10:00-10:59 11 = 11:00-11:59 23 = 11:00-11:59 99 = Unknown</p>
Required for inpatient claims	17:	<p>Patient Status Required for outpatient claims if the patient status code is other than 01. Enter patient status code.</p>

		<p>Valid Patient Status Codes:</p> <p>01 = Discharged to home or self-care (routine discharge) 02 = Discharged/transferred to another acute short-term general hospital for inpatient care 03 = Discharged/transferred to a SNF 04 = Discharged/transferred to an ICF 05 = Discharged/transferred to another type of institution not defined elsewhere in this code list 06 = Discharged/transferred to home under care organized home health service organization 07 = Left against medical advice or discontinued care 08 = Reserved for National Assignment 09 = Admitted as an inpatient to this hospital 20 = Expired</p> <p>30 = Still patient or expected to return for outpatient services</p> <p>The following are used only on hospice claims:</p> <p>40 = Expired at home 41 = Expired in a medical facility, such as a hospital, SNF, ICF or freestanding hospice 42 = Expired – place unknown 43 = Discharged/transferred to a federal health care facility 50 = Discharged/transferred to Hospice – home 51 = Discharged/transferred to Hospice – medical facility 61 = Discharged/transferred within this institution to a hospital-based Medicare approved swing bed 62 = Discharges/transferred to <u>an</u> inpatient rehabilitation facility including distinct part units of a “hospital” 63 = Discharge/transferred to long term care hospital 64 = Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 = Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 = Discharged/transferred to a Critical Access Hospital</p>
Recommended	18 – 28:	<p>Condition Codes</p> <p>Enter the corresponding code (in numerical order) to describe any of the following conditions or events that apply to this billing period. We can only accept up to 10 condition codes.</p> <p>Valid Condition Codes</p> <p>02 = Condition is Employment Related 03 = Patient Covered by Insurance Not Reflected</p>

		<p>04 = Information Only Bill 05 = Lien Has Been 06 = ESRD Patient in the First 30 Months of Entitlement Covered By Employer Group Health Insurance 07 = Treatment of Non-terminal Condition for Hospice Patient 08 = Beneficiary Would Not Provide Information Concerning Other Insurance Coverage. 09 = Neither Patient Nor Spouse is Employed 10 = Patient and/or Spouse is Employed but no EGHP Coverage 11 = Disabled Beneficiary But no Large Group Health Plan</p> <p>12-14 = Payer codes reserved for internal use only by third party payers.</p> <p>17 = Patient is Homeless 18 = Maiden Name Retained 19 = Child Retains Mother's Name 20 = Beneficiary Requested 21 = Billing for Denial Notice 26 = VA Eligible Patient Chooses to Receive Services In a Medicare Certified Facility 27 = Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test (Sole Community Hospitals only). 28 = Patient and/or Spouse's EGHP is Secondary to Medicare 29 = Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare 30 = Qualifying Clinical Trials</p> <p>Student Status 31 = Patient is a Student (Full-Time - Day) 32 = Patient is a Student (Cooperative/Work Study Program) 33 = Patient is a Student (Full-Time - Night) 34 = Patient is a Student (Part-Time)</p> <p>Accommodation 36 = General Care Patient in a Special Unit (Not used by hospitals under PPS 37 = Ward Accommodation at Patient's Request (Not used by hospitals under PPS.) 38 = Semi-private Room Not Available (Not used by hospitals under PPS 39 = Private Room Medically Necessary (Not used by hospitals under PPS 40 = Same Day Transfer</p>
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	<p>41 = Partial Hospitalization 42 = Continuing Care Not Related to Inpatient Admission 43 = Continuing Care Not Provided Within Prescribed Post Discharge Window 44 = Inpatient Admission Changed to Outpatient 46 = Non-Availability Statement on File 47 = Reserved for TRICARE 48 = Psychiatric Residential Treatment Centers for Children and Adolescents (RTCs) 49 = Product replacement within product</p> <p>Skilled Nursing Facility Information 55 = SNF Bed Not Available 56 = Medical Appropriateness 57 = SNF Readmission</p> <p>58 = Terminated Managed Care Organization Enrollee 59 = Non-primary ESRD Facility 67 = Beneficiary Elects Not to Use Lifetime Reserve (LTR) 69 = IME/DGME/N&A Payment Only</p> <p>Renal Dialysis Setting 71 = Full Care in Unit 72 = Self-Care in Unit 73 = Self-Care Training 74 = Home 75 = Home 100-percent 76 = Back-up In-Facility Dialysis 77 = Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by the Primary Payer as Payment in Full 78 = New Coverage Not Implemented by Managed Care Plan 79 = CORF Services Provided Off-Site 80 = Home Dialysis-Nursing Facility</p> <p>A9 = Second Opinion Surgery</p> <p>AA = Abortion Performed due to Rape AB = Abortion Performed due to Incest AC = Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality AD = Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising From or Exacerbated by the Pregnancy Itself AE = Abortion Performed due to Physical Health of Mother that is not Life Endangering AF = Abortion Performed due to Emotional/psychological Health of the Mother AG = Abortion Performed due to Social Economic Reasons</p>
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		<p>AH = Elective Abortion Self AI = Sterilization Self-explanatory</p> <p>AJ = Payer Responsible for Copayment AK = Air Ambulance AL = Specialized Treatment/bed Unavailable AM = Non-emergency Medically Necessary Stretcher Transport Required AN = Preadmission Screening Not Required</p> <p>B1 = Beneficiary is Ineligible for Demonstration Program B2 = Critical Access Hospital Ambulance Attestation B3 = Pregnancy Indicator B4 = Admission Unrelated to Discharge</p> <p>Quality Improvement Organization (QIO) C1 = Approved as Billed C3 = Partial Approval C4 = Admission Denied C5 = Post-payment Review Applicable C6 = Preadmission/Pre-procedure C7 = Extended Authorization</p> <p>D0 = Changes to Service Dates D1 = Changes to Charges D2 = Changes to Revenue Codes/HCPCS/HIPPS Rate Code D3 = Second or Subsequent Interim PPS Bill D4 = Changes In ICD-9-CM Diagnosis and/or Procedure Code D5 = Cancel to Correct HICN or Provider ID D6 = Cancel Only to Repay a Duplicate or OIG Overpayment D7 = Change to Make Medicare the Secondary Payer D8 = Change to Make Medicare the Primary Payer D9 = Any Other Change DR = Disaster related</p> <p>E0 = Change in Patient Status G0 = Distinct Medical Visit H0 = Delayed Filing, Statement Of Intent Submitted</p>
Required for automobile accidents	29	<p>Accident State Two-digit state abbreviation of the state where the accident occurred.</p>
	30	<p>Untitled Not used.</p>

<p>Recommended Required for all accidents</p>	<p>31 – 41:</p>	<p>Occurrence Codes and Dates Required when there is a condition code that applies to this claim. Form locators 31, 32, 33, and 34 – allow both an occurrence codes and a date. Dates must be in MMDDYY format. The Occurrence Span Code can contain an occurrence code where the “Through” date would not contain an entry.</p> <p>Valid Occurrence Codes</p> <p>Accident Related Codes 01 = Accident/Medical Coverage 02 = No-Fault Insurance Involved 03 = Accident/Tort Liability 04 = Accident/Employment Related 05 = Accident/No Medical or Liability Coverage 06 = Crime Victim</p> <p>Medical Condition Codes 09 = Start of Infertility Treatment Cycle 10 = Last Menstrual Period 11 = Onset of Symptoms/Illness (Outpatient claims only.) 12 = Date of Onset for a Chronically Dependent Individual (CDI) (HHA Claims Only)</p> <p>Insurance Related Codes 16 = Date of Last Therapy 17 = Date Outpatient Occupational Therapy Plan Established or Reviewed 18 = Date of Retirement Patient/Beneficiary. 19 = Date of Retirement Spouse 20 = Guarantee of Payment Began (Part A hospital claims only) 21 = UR Notice Received (Part A SNF claims only.) 22 = Date Active Care Ended 23 = Date of Cancellation of Hospice Election Period 24 = Date Insurance Denied 25 = Date Benefits Terminated by Primary Payer 26 = Date SNF Bed Available 27 = Date of Hospice Certification or Re-Certification 28 = Date CORF Plan Established or Last 29 = Date OPT Plan Established or Last Reviewed 30 = Date Outpatient Speech Pathology Plan Established or Last Reviewed 31 = Date Beneficiary Notified of Intent to Bill (Accommodations) 32 = Date Beneficiary Notified of Intent to Bill (Procedures or Treatments) 33 = First Day of the Medicare Coordination Period for ESRD Beneficiaries Covered by an EGHP</p>
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		<p>34 = Date of Election of Extended Care Services 35 = Date Treatment Started for Physical Therapy 36 = Date of Inpatient Hospital Discharge for a Covered Transplant Procedure(s) 37 = Date of Inpatient Hospital Discharge - Patient Received Non-covered Transplant 38 = Date treatment started for Home IV Therapy 39 = Date discharged on a continuous course of IV 40 = Scheduled Date of Admission 41 = Date of First Test for Pre-admission Testing 42 = Date of Discharge (Hospice claims only) 43 = Scheduled Date of Cancelled Surgery 45 = Date Treatment Started for Speech Therapy 46 = Date Treatment Started for Cardiac 47 = Date Cost Outlier Status Begins</p> <p>Service Related Codes A1 = Birth Date-Insured A The birth-date of the insured in whose name the insurance is carried. A2 = Effective Date-Insured A Policy A3 = Benefits Exhausted A4 = Split Bill Date B1 = Birth Date-Insured B B2 = Effective Date-Insured B Policy B3 = Benefits Exhausted C1 = Birth Date-Insured C C2 = Effective Date-Insured C Policy C3 = Benefits Exhausted 70 = Qualifying Stay Dates (Part A claims for SNF level of care only) 71 = Hospital Prior Stay Dates (Part A claims only) 72 = First/Last Visit 74 = Non-covered Level of Care</p> <p>Codes 76 and 77 apply to most non-covered care 76 = Patient Liability The From/Through dates for a period of non-covered care for which the provider is permitted to charge the beneficiary. 77 = Provider Liability- Utilization Charged The From/Through dates of a period of care for which the provider is liable (other than for lack of medical necessity or custodial care) M2 = Dates of Inpatient Respite From/Through dates of a period of inpatient M3 = ICF Level of Care M4 = Residential Level of Care</p>
	37:	<p>Untitled Not used.</p>

	38:	Responsible Party Name and Address
Required	39 – 41 a - d:	<p>Value Codes and Amounts Enter value code. Amount is required when a value code is entered. If value code 45 is entered then amount needs to reflect an admission hour (see Form Locator 13).</p> <p>Valid Value Codes 01 = Most common semi-private rate 02 = Hospital has no semi-private rooms 03 = Inpatient professional component charges which are combined billed 04 = Inpatient professional component charges which are combined billed 05 = Professional component included in charges and also billed separate to carrier 06 = Medicare blood deductible 08 = Medicare life time reserve amount in the first calendar year 09 = Medicare coinsurance amount in the first calendar year 10 = Lifetime reserve amount in the second calendar year 11 = Coinsurance amount in the second calendar year 12 = Working aged beneficiary/spouse with employer group health plan. 13 = ESRD beneficiary in a Medicare coordination period with an employer group health plan 14 = No fault, including auto/other 15 = Worker's compensation 16 = PHS or other federal agency</p> <p>Medicaid Specific Codes 21 = Catastrophic 22 = Surplus 23 = Recurring monthly income 24 = Medicaid rate code</p> <p>Reserved Codes 31 = Patient liability amount 32 = Multiple Patient Ambulance Transport 37 = Pints of blood furnished 38 = Blood deductible pints 39 = Pints of blood replaced 40 = New coverage not implemented by HMO (for inpatient service only) 41 = Black Lung</p>

		<p>42 = VA 43 = Disabled beneficiary under age 65 with LGHP 44 = Amount provider agreed to accept from primary payer when this amount is less than charges but higher than payment received, then a Medicare secondary payment is due 45 = Accident Hour 46 = Number of grace days 47 = Any liability insurance 48 = Hemoglobin reading 49 = Hematocrit reading 50 = Number of physical therapy visits from onset (at the billing provider through this billing period) 51 = Number of occupational therapy visits from onset of symptoms (at the billing provider through this billing period) 52 = Number of speech therapy visits from onset of symptoms (at the billing provider) 53 = Number of cardiac rehabilitation visits (at the billing provider through this billing period) 54 = Newborn birth weight in grams</p> <p>Home Health Specific Codes 56 = Skilled nursing - home visit hours (HHA only) 57 = Home health aide - home visit hours (HHA only) 58 = Arterial blood gas value 59 = Oxygen saturation value 60 = HHA branch MSA 61 = Place of residence where service is furnished (HHA and Hospice) 67 = Peritoneal dialysis 68 = Number of units of EPO drug administered and/or supplied 71 = Funding of ESRD Networks 72 = Flat Rate Surgery Charge 73 = Drug deductible 74 = Drug coinsurance 76 = Provider's Interim Rate 80 = Covered days 81 = Non-covered days 82 = Co-insurance days 83 = Lifetime Reserve days</p> <p>Deductible Coinsurance Codes A1 = Deductible amount Payer A</p>
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Required for each charge entered	42:	<p>Revenue Code An accommodation revenue code (0100-0219) is required for all inpatient type of bill (TOB).</p>
Optional	43:	<p>Revenue Description A narrative description of the related revenue categories included on the claim. Abbreviations may be used.</p>
Required	44:	<p>HCPCS/Rates/HIPPS Rate Codes A CPT or HCPCS code is required for outpatient services or supplies.</p>
Required	45:	<p>Service Date Enter the date that the services were provided. Must be in MMDDCCYY format.</p>
Required	46:	<p>Units of Service Enter the number of units rendered for each service. Units can be hours, days/sessions, tests/services or items</p>
Required for each revenue code entered	47:	<p>Total Charges Enter total charges Enter total charges pertaining to the related revenue code for the current billing period. Zeros are valid.</p>

Optional	48:	Non-Covered Charges Enter non-covered charges.
	49:	Untitled Not used.
	51 a- c:	Health Plan ID See Form locators 56 and 57 for NPI and Regence Identifier fields.
Required	52 a – c:	Release of Information Certification Indicator A “Y” code indicates that the provider has on file a signed statement permitting it to release data to other organizations in order to adjudicate the claim. This is required when state or federal laws do not supersede the HIPAA Privacy Rule by requiring that a signature be collected. An “I” code indicates Informed Consent to Release Medical Information for Conditions or Diagnoses Regulated by Federal Statutes.
Optional	53 a – c:	Assignment of Benefits Certification Indicator
Optional	54 a – c:	Prior Payments-Payers and Patient Enter the amount of the prior payments from other insurance.
Optional	55 a – c:	Estimated Amount Due from patient
Required for electronic claim submissions	56:	Billing Provider National Provider ID (NPI) The billing provider NPI must be entered on all electronic claim submissions. While not a requirement, we recommend that claims submitted on paper also indicate an NPI.
Required for paper claim submissions if NPI is not submitted in form locator 56	57:	Other Provider ID (primary, secondary, and/or tertiary) Use this field to report your Regence provider identification number if submitting a paper claim without an NPI. Until further notice a billing provider can electronically submit both an NPI and a Regence provider identification number.

Required	58 a – c:	Insured’s Name Enter the insured’s last name, first name and middle initial as it appears on the member card.
Required	59 a – c:	Patient’s Relationship to Insured Enter patient’s relationship to insured code. 01 = Spouse 18 = Self 19 = Child 20 = Employee 21 = Unknown 39 = Organ Donor 40 = Cadaver Donor 53 = Life Partner G8 = Other Relationship
Required	60 a – c:	Insured’s Unique Identification (ID) Enter insured’s identification number as shown on member card.
Optional	61 a – c:	Insured’s Group Name
Required	62 a – c:	Insurance Group Number Enter the insured’s group number as shown on the member card. Exception: If a member card from another Blue Cross and/or BlueShield Plan does not show a group number - leave the field blank or populate the field with a numeric (e.g., 99999999)
Optional	63:	Treatment Authorization Code
Optional	64:	Document Control Number (DCN)
Optional	65:	Employer Name
Optional	66:	Diagnosis and Procedure Code Qualifier (ICD Version Indicator) The qualifier denotes the version of <i>International Classification of Diseases</i> (ICD) reported. The following qualifier code reflects the edition portion of the ICD 9 – Ninth Revision

Required	67:	<p>Principal Diagnosis Code and Present on Admission Indicator</p> <p>Enter the ICD-9 diagnosis code for the principal diagnosis. The principal diagnosis is the condition established after study to be chiefly responsible for this hospital admission. The code must be the full ICD-9 diagnosis code, including all five digits where applicable. Do not include the decimal between the third and fourth digits. "V" codes are acceptable as principal diagnoses.</p> <p>This field is eight positions long. The principal diagnosis is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.</p>
Required	67A – 67Q:	<p>Other Diagnoses Codes</p> <p>Enter up to seventeen ICD-9 diagnosis codes for the other diagnoses. The codes must be the full ICD-9 diagnosis codes, including all five digits where applicable. Do not include the decimal between the third and fourth digits. Both "V" and "E" codes may be entered as other diagnoses, though E codes are preferably billed in form locator 72.</p> <p>There are 17 Other Diagnosis fields. Each Other Diagnosis field is eight positions long. The diagnosis code is entered in positions 1 - 3, 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.</p> <p>Diagnosis codes must be carried to their highest degree of detail. Do not duplicate the principal diagnosis in this field.</p>
	68:	<p>Untitled Not used.</p>
Required for inpatient type of bills	69:	<p>Admitting Diagnosis</p> <p>Must be a valid ICD diagnosis code. Admitting diagnosis is the condition identified by the physician at the time of the patient's admission requiring hospitalization.</p>
Required for outpatient if applicable	70 a – c:	<p>Patient's Reason for Visit</p> <p>Required for all unscheduled outpatient visits for outpatient bills.</p>
Optional	71:	<p>Prospective Payment System (PPS) Code</p>

Required if applicable	72:	External Cause of Injury Code (E-Code) Enter up to three E-Codes if an injury, poisoning or adverse effect is the cause for seeking medical treatment or occurs during the medical treatment. The codes must be the full ICD-9 E-code, including all five digits where applicable. Do not include the decimal between the fourth and fifth positions. There are 3 E-Code fields. Each E-Code field is eight positions long. The E-Code is entered in positions 1 - 4 or 5, as needed. Present on Admission (POA) is entered in position 8. The POA area is shaded on the paper form.
	73:	Untitled Not used.
Required for inpatient type of bills if applicable	74:	Principal Procedure Code and Date Enter the principal procedure code and date. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
Required for inpatient type of bills if applicable	74A – 74E:	Other Procedure Codes and Dates Enter up to five other procedure codes and dates. The procedure code must a valid ICD-9 procedure code. Do not include the decimal between the second and third digits. The date must be in the MMDDYY format.
	75:	Untitled Not used.
Required	76:	Attending Provider Name and Identifiers (including NPI) Enter the unique provider's NPI and the name of the attending physician for inpatient bills or the physician that requested the outpatient services. Definition of attending provider: The provider who is the individual who has overall responsibility for the patient's medical care and treatment reported in this claim/encounter.
Optional	77:	Operating Provider Name and Identifiers (including NPI)
Optional	78 and 79:	Other Provider Name and Identifiers (including NPI)

<p>Required under the circumstances listed</p>	<p>80:</p>	<p>Remarks</p> <ol style="list-style-type: none"> 1. Enter accident information if occurrence codes 01-05 are entered and/or diagnosis codes 800-959.9, E800-849, E880-E929, E969-E999 are entered. 2. Specify the type of drug, implant, or device if a HCPCS code cannot identify them. 3. Specify if ionic or non-ionic contrast media was used for revenue codes 0255, 0350, 0351, 0352, or 0359. 4. Enter information relating to emergency room visit if revenue code 0450 or 0459 is used. 5. Enter description of service, training schedule or name of educational program if revenue code 0942 is used. 6. Facilities with programs for partial day and intensive outpatient programs should indicate “full” partial, “half” partial, or intensive outpatient program. This additional information will help determine the correct benefits when processing the claim.
<p>Recommended</p>	<p>81:</p>	<p>Code-Code Field Enter for the following: A1 = NUBC Condition Codes (FL 18-28) A2 = NUBC Occurrence Codes/Dates A3 = NUBC Occurrence Span A4 = NUBC Value Codes (FL 39-41)</p>

Sample UB-04 claim form

1		2		3A PRT. CNTRL. #		4 TYPE OF BILL	
				3B MED. RES. #			
				5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM THROUGH	
8 PATIENT NAME		9 PATIENT ADDRESS					
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION	
						14 HR	
						15 SEC	
						16 DR	
						17 STAFF	
						18	
						19	
						20	
						21	
						22	
						23	
						24	
						25	
						26	
						27	
						28	
						29 ACCT STATE	
						30	
31 OCCURRENCE DATE		32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE	
35 OCCURRENCE DATE		36 OCCURRENCE CODE		37 OCCURRENCE DATE		38 OCCURRENCE CODE	
39		40		41		42	
a		b		c		d	
b		c		d		e	
c		d		e		f	
d		e		f		g	
e		f		g		h	
f		g		h		i	
g		h		i		j	
h		i		j		k	
i		j		k		l	
j		k		l		m	
k		l		m		n	
l		m		n		o	
m		n		o		p	
n		o		p		q	
o		p		q		r	
p		q		r		s	
q		r		s		t	
r		s		t		u	
s		t		u		v	
t		u		v		w	
u		v		w		x	
v		w		x		y	
w		x		y		z	
x		y		z		aa	
y		z		aa		ab	
z		aa		ab		ac	
aa		ab		ac		ad	
ab		ac		ad		ae	
ac		ad		ae		af	
ad		ae		af		ag	
ae		af		ag		ah	
af		ag		ah		ai	
ag		ah		ai		aj	
ah		ai		aj		ak	
ai		aj		ak		al	
aj		ak		al		am	
ak		al		am		an	
al		am		an		ao	
am		an		ao		ap	
an		ao		ap		aq	
ao		ap		aq		ar	
ap		aq		ar		as	
aq		ar		as		at	
ar		as		at		au	
as		at		au		av	
at		au		av		aw	
au		av		aw		ax	
av		aw		ax		ay	
aw		ax		ay		az	
ax		ay		az		ba	
ay		az		ba		bb	
az		ba		bb		bc	
ba		bb		bc		bd	
bb		bc		bd		be	
bc		bd		be		bf	
bd		be		bf		bg	
be		bf		bg		bh	
bf		bg		bh		bi	
bg		bh		bi		bj	
bh		bi		bj		bk	
bi		bj		bk		bl	
bj		bk		bl		bm	
bk		bl		bm		bn	
bl		bm		bn		bo	
bm		bn		bo		bp	
bn		bo		bp		bq	
bo		bp		bq		br	
bp		bq		br		bs	
bq		br		bs		bt	
br		bs		bt		bu	
bs		bt		bu		bv	
bt		bv		bw		bx	
bv		bw		bx		by	
bw		bx		by		bz	
bx		by		bz		ca	
by		bz		ca		cb	
bz		ca		cb		cc	
ca		cb		cc		cd	
cb		cc		cd		ce	
cc		cd		ce		cf	
cd		ce		cf		cg	
ce		cf		cg		ch	
cf		cg		ch		ci	
cg		ch		ci		cj	
ch		ci		cj		ck	
ci		cj		ck		cl	
cj		ck		cl		cm	
ck		cl		cm		cn	
cl		cm		cn		co	
cm		cn		co		cp	
cn		co		cp		cq	
co		cp		cq		cr	
cp		cq		cr		cs	
cq		cr		cs		ct	
cr		cs		ct		cu	
cs		ct		cu		cv	
ct		cu		cv		cw	
cu		cv		cw		cx	
cv		cw		cx		cy	
cw		cx		cy		cz	
cx		cy		cz		da	
cy		cz		da		db	
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df		dg		dh		di	
dg		dh		di		dj	
dh		di		dj		dk	
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dj		dk		dl		dm	
dk		dl		dm		dn	
dl		dm		dn		do	
dm		dn		do		dp	
dn		do		dp		dq	
do		dp		dq		dr	
dp		dq		dr		ds	
dq		dr		ds		dt	
dr		ds		dt		du	
ds		dt		du		dv	
dt		du		dv		dw	
du		dv		dw		dx	
dv		dw		dx		dy	
dw		dx		dy		dz	
dx		dy		dz		ea	
dy		dz		ea		eb	
dz		ea		eb		ec	
ea		eb		ec		ed	
eb		ec		ed		ee	
ec		ed		ee		ef	
ed		ee		ef		eg	
ee		ef		eg		eh	
ef		eg		eh		ei	
eg		eh		ei		ej	
eh		ei		ej		ek	
ei		ej		ek		el	
ej		ek		el		em	
ek		el		em		en	
el		em		en		eo	
em		en		eo		ep	
en		eo		ep		eq	
eo		ep		eq		er	
ep		eq		er		es	
eq		er		es		et	
er		es		et		eu	
es		et		eu		ev	
et		eu		ev		ew	
eu		ev		ew		ex	
ev		ew		ex		ey	
ew		ex		ey		ez	
ex		ey		ez		fa	
ey		ez		fa		fb	
ez		fa		fb		fc	
fa		fb		fc		fd	
fb		fc		fd		fe	
fc		fd		fe		ff	
fd		fe		ff		fg	
fe		ff		fg		fh	
ff		fg		fh		fi	
fg		fh		fi		fj	
fh		fi		fj		fk	
fi		fj		fk		fl	
fj		fk		fl		fm	
fk		fl		fm		fn	
fl		fm		fn		fo	
fm		fn		fo		fp	
fn		fo		fp		fq	
fo		fp		fq		fr	
fp		fq		fr		fs	
fq		fr		fs		ft	
fr		fs		ft		fu	
fs		ft		fu		fv	
ft		fu		fv		fw	
fu		fv		fw		fx	
fv		fw		fx		fy	
fw		fx		fy		fz	
fx		fy		fz		ga	
fy		fz		ga		gb	
fz		ga		gb		gc	
ga		gb		gc		gd	
gb		gc		gd		ge	
gc		gd		ge		gf	
gd		ge		gf		gg	
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gf		gg		gh		gi	
gg		gh		gi		gj	
gh		gi		gj		gk	
gi		gj		gk		gl	
gj		gk		gl		gm	
gk		gl		gm		gn	
gl		gm		gn		go	
gm		gn		go		gp	
gn		go		gp		gq	
go		gp		gq		gr	
gp		gq		gr		gs	
gq		gr		gs		gt	
gr		gs		gt		gu	
gs		gt		gu		gv	
gt		gu		gv		gw	
gu		gv		gw		gx	
gv		gw		gx		gy	
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Hospital Billing

Revenue Codes

Regence BlueShield of Idaho requires CPT codes and modifiers on the UB-04 form in conjunction with specific revenue codes. Below is a listing which indicates if CPT/HCPCS/modifiers are required for each specific revenue code. If you are billing a revenue code that has a “Yes” in the CPT required column for that code, the billing must also have the appropriate CPT code(s) on the UB-04. Any claim submitted without the appropriate CPT codes will be denied as an incomplete claim. As a reminder, professional services are required to be billed on a CMS-1500 form.

Regence BlueShield of Idaho Revenue Codes for UB-04 Claims		
Revenue Code	Revenue Code Description	CPT Required
0001	Total Charge	No
001X	Reserved for Internal Payer Use	No
002X	New Revenue category- (HIPPS) Health Insurance Prospective Payment System for Skilled Nursing Fee Prospective Payment System	No
0023	Home Health	No
0024	Inpatient Rehabilitation Facility- Prospective Payment System	No
003X to 006X	Reserved for National Assignment	No
007X to 009X	Reserved for State Use	No
010X	All Inclusive Rate	No
011X	Room & Board - Private	No
012X	Room & Board - Semi-Private Two Bed	No
013X	Semi-Private - Three & Four Beds	No
014X	Private (Deluxe)	No
015X	Room & Board - Ward	No
016X	Other Room & Board	No
017X	Nursery	No
018X	Leave of Absence	No
019X	Subacute Care	No
020X	Intensive Care	No
021X	Coronary Care	No
022X	Special Charges	No
023X	Incremental Nursing Charges	No
024X	All Inclusive Ancillary	No
025X	Pharmacy	No
026X	IV Therapy	Yes

Revenue Code	Revenue Code Description	CPT Required
027X	Medical/Surgical Supplies	No
028X	Oncology	Yes
029X	Durable Medical Equipment (other than rental)	No
030X	Laboratory	Yes
031X	Laboratory Pathological	Yes
032X	Radiology - Diagnostic	Yes
033X	Radiology - Therapeutic	Yes
034X	Nuclear Medicine	Yes
035X	Computed Tomographic (CT) Scan	Yes
036X	Operating Room Services	Yes
037X	Anesthesia	No
038X	Blood	No
039X	Blood Storage and Processing	No
040X	Other Imaging Services	Yes
041X	Respiratory Services	Yes
042X	Physical Therapy	Yes
043X	Occupational Therapy	Yes
044X	Speech - Language Pathology	Yes
045X	Emergency Room	Yes
046X	Pulmonary Function	Yes
047X	Audiology	Yes
048X	Cardiology	Yes
049X	Ambulatory Surgical Care	Yes
050X	Outpatient Services	Yes
051X	Clinic	Yes
052X	Freestanding Clinic	No
053X	Osteopathic Services	Yes
054X	Ambulance	No
055X	Skilled Nursing	No
056X	Medical Social Services	No
057X	Home Health Aide (Home Health)	No
058X	Other Visits (Home Health)	No
059X	Units of Service (Home Health)	No
060X	Oxygen (Home Health)	No
061X	Magnetic Resonance Imaging (MRI)	Yes
062X	Medical/Surgical Supplies (extension of 27X)	No
063X	Pharmacy (extension of 025X)	No
064X	Home IV Therapy Services	No
065X	Hospice Services	No
066X	Respite Care (HHA only)	No
067X	Outpatient Special Residence Charges	No

Revenue Code	Revenue Code Description	CPT Required
068X	Trauma Response/ charges for a trauma team activation	No
070X	Cast Room	No
071X	Recovery Room	No
072X	Labor Room/Delivery	No
073X	Electrocardiogram (EKG/ECG)	Yes
074X	Electroencephalogram (EEG)	Yes
075X	Gastrointestinal Services (Use for endoscopic procedures not performed in an operating room)	Yes
076X	Treatment or Observation Room	Yes
077X	Preventive Care Services	No
079X	Extra-Corporeal Shock Wave Therapy or ESWT (formerly Lithotripsy)	Yes
080X	Inpatient Renal Dialysis	No
081X	Organ Acquisition	No
082X	Hemodialysis - Outpatient or Home	No
083X	Peritoneal Dialysis - Outpatient or Home	Yes
084X	Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	Yes
085X	Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient	Yes
086X	Reserved	No
087X	Reserved	No
088X	Miscellaneous Dialysis	Yes
090X	Behavior Health Treatment /Services (also see 091X, an extension of 090X)	Yes
091X	Behavioral Health Treatment/Services (extension of 090X)	Yes
092X	Other Diagnostic Services	Yes
093X	Medical Rehabilitation Day Program	No
094X	Other Therapeutic Services (also see 095X, an extension of 094X)	No
095X	Other Therapeutic Services (Extension of 094X)	No
096X	Professional Fees	No
097X	Professional Fees (Extension of 096X)	No
098X	Professional Fees (Extension of 96X & 97X)	No
099X	Patient Convenience Items	No
100X	Behavioral Health Accommodations	No
210X	Alternative Therapy Services	No
211X to 300X	Reserved for National assignment	No
310X	Adult Care	No
311X to 899X	Reserved for National assignment	No
9000 to 9044	Reserved for Medicare Skilled Nursing Facility Demonstration Project	No
9045 to 9099	Reserved for National assignment	No

Copayment Policies

Office Visit Copayments

Members have an office visit copayment obligation at the time of service. Only one copayment per member should be collected for each visit regardless of the service provided.

Facility Copayments

Members have a facility copayment obligation at the time of service. However, payment arrangements between the member and the facility may be made in cases where larger copayment amounts exist. Only one copayment per member should be collected for each visit per day.

Maternity Copayments

This copayment is collected by the physician and is associated with the global fee for maternity services. Members should pay their copayment prior to delivery, either on a per visit basis or in total by a specified date.

If the pregnancy terminates or if the member transfers to another physician prior to delivery, an office visit copayment should be collected for each prenatal visit. This should not exceed the total copayment for global maternity care.

Member Compliance

If a managed care member is repeatedly noncompliant in making copayments, please notify our customer service staff. The member education staff will counsel managed care members regarding their responsibility to make copayments at the appropriate time.

Maximum Copayment Liability

Physician and other health care professional vouchers will indicate the members who have reached their maximum copayment liability for the current calendar year. If a member has met his or her maximum copayment liability, copayments for office visits should not be collected during the remainder of the calendar year. After the maximum member copayment liability is met, covered benefits will be paid to the physician without copayment amounts deducted.

The member may notify a network specialist or hospital, at the time of service, that their maximum copayment liability has been met. Verify this information by utilizing Regence Online Services for Providers or by contacting our customer service department.

Miscellaneous Billing Information

Multiple Surgical Procedures

When multiple procedures are performed during the same operative session, the procedure with the highest allowable reimbursement will be considered the primary procedure. It will be reimbursed at 100% of the allowable rate. The next five covered procedures will be reimbursed at 50% of the allowable rate.

For ambulatory surgery centers and surgical suites, operating room reports are required for the seventh and subsequent procedures reported with modifier -51. Our physician reviewer has the discretion to determine the rate at which those procedures will be reimbursed.

All procedures, including bilateral procedures, performed in one operative session must be billed together. Bilateral procedures, which are performed in one operative session, will be reimbursed using the same methodology used for multiple procedures. They must be reported using modifier -50.

Certain procedures are considered “incidental” and are not eligible for payment as secondary procedures. An incidental procedure is one that does not add significant time or complexity to the major procedure.

Intraocular Lens Reimbursement for Ambulatory Surgery Centers

Payment for intraocular lenses is included in the ASC reimbursement, with the exception of the new technology intraocular lens category 1 as defined in the Federal Register notice. These lenses must be reported with **HCPCS code Q1001**.

Reimbursement Methodology for Terminated Procedures

With the following exceptions, procedures terminated for any reason are not eligible for reimbursement:

- ASC will be reimbursed at 50% of the allowable rate if the procedure is terminated for medical necessity after the patient has been prepared for surgery and taken to the operating room, but before anesthesia has been administered. You must use modifier -73 to report these procedures.
- ASC will be reimbursed at 100% of the allowable reimbursement rate if the procedure is terminated for medical necessity after anesthesia has been administered. Use modifier -74 to report these procedures.

Anesthesia Services

Anesthesia is the administration of a drug or other anesthetic agent by injection or inhalation to obtain muscular relaxation, loss of sensation and/or loss of consciousness. Types of anesthesia may include inhalation, regional, spinal, epidural, nerve block, field block, intravenous or rectal.

Reimbursement Guidelines for Maternity Labor

Codes 01967 – 01969 are eligible for reimbursement. Add-on **anesthesia codes 01968 and 01969** are to be reported in addition to the primary **anesthesia code (01967)**. The ASA value from both the primary and add-on anesthesia codes are eligible for reimbursement in addition to the time units.

Codes 01967-01969 are eligible for four (4) time units for the first hour and two (2) additional times units for the second and subsequent hours.