



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

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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.

Sample PCS Recoupment

DATE: MM/DD/YY
 PROVIDER NUMBER: 0001112222
 CHECK NUMBER: 123456789
 TAX IDENTIFICATION NUMBER: 987654321

1
2
3
4

5 ABC MEDICAL GROUP
 123 MAIN STREET
 ANYTOWN, TX 70000

ANY MESSAGES WILL APPEAR ON PAGE 1

6 PATIENT: JOHN DOE
7 PERF PRV: 1234567890
8 CLAIM NO: 00001234567890C
9 IDENTIFICATION NO: P06666-XOC123456789
10 PATIENT NO: 12345KB

11	12	13	14	15	16	17	18	19
FROM/TO DATES	PS*	PAY	PROC CODE	AMOUNT BILLED	ALLOWABLE AMOUNT	SERVICES NOT COVERED	DEDUCTIONS/ OTHER INELIGIBLE	AMOUNT PAID
02/09 – 02/09/12	03	HMO	99213	76.00	50.52	(1) 25.48	0.00	50.52
				76.00	50.52	25.48	0.00	50.52

20 AMOUNT PAID TO PROVIDER FOR THIS CLAIM: \$50.52

DEDUCTIONS/OTHER INELIGIBLE

21 TOTAL SERVICES NOT COVERED: 25.48
22 PATIENT'S SHARE: 0.00

PROVIDER CLAIMS AMOUNT SUMMARY

23 NUMBER OF CLAIMS: 1	AMOUNT PAID TO SUBSCRIBER: \$0.00
AMOUNT BILLED: \$76.00	AMOUNT PAID TO PROVIDER: \$50.52
AMOUNT OVER MAXIMUM ALLOWANCE: \$25.48	RECOUPMENT AMOUNT: \$31.52
AMOUNT OF SERVICES NOT COVERED: \$25.48	NET AMOUNT PAID TO PROVIDER: \$19.00
AMOUNT PREVIOUSLY PAID: \$0.00	

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

25 MESSAGES:
 (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.

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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	Address of the provider/group who 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 the provider
11	From/To Dates	The beginning and ending dates of services
12	PS	Place of service
13	PAY	Reimbursement payment rate that was applied in relationship to the member's policy type
14	Procedure Code	The code that identifies the procedure performed
15	Amount Billed	The amount billed for each procedure/service
16	Allowable Amount	The highest amount BCBSNM will pay for a specific type of medical procedure.
17	Services Not Covered	Non-covered services according to the member's contract
18	Deductions/Other Ineligible	Program deductions, copayments, and coinsurance amounts
19	Amount Paid	The amount paid for each procedure/service
20	Amount Paid to Provider for This Claim	The amount Blue Shield paid to provider for 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 Summary	How all of the claims on the PCS were 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