# Providers' News

Arkansas BlueCross BlueShield

To: All Providers

From: Provider Network Operations

Date: June 2002

Please Note: This newsletter contains information pertaining to Arkansas Blue Cross and Blue Shield (ABCBS), a mutual insurance company, its wholly owned subsidiaries and affiliates. This newsletter does not pertain to Medicare. Medicare policies are outlined in the Medicare Providers' News bulletins. If you have any questions, please feel free to call (501) 378-2307 or (800) 827-4814.

## What's Inside?




"Any five-digit Physician's Current Procedural Terminology (CPT) codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2001 American Medical Association. All Rights Reserved."

## Anesthesia Billing:

Evaluation and Management codes billed during the period beginning three days prior to and ending ten days after an anesthesia procedure are considered part of the anesthesia procedure and will be denied as a fragmentation of the anesthesia procedure. This applies only to ABCBS and Health Advantage claims.

## Arkansas FirstSource PPO Access-Only:

### • Claim Filing:

**Please remember to use your Arkansas Blue Cross and Blue Shield provider number when filing claims for Arkansas' FirstSource PPO Access-Only groups.** Using your Tax ID number in fields 24K and 33 on HCFA 1500 claim forms or in field 51 on UB92 claim forms will delay processing and could cause your claim to be paid to another provider.

Submit all Arkansas' FirstSource Access-Only claims to ABCBS unless specifically instructed otherwise on the patient's ID card**.** Submitting claims directly to Wal-Mart or Third Party Administrators (TPA's) will only delay payment of your claim.

**Access-Only claims may be submitted electronically with your ABCBS and USAble PPO claims.** If you are unable to submit claims electronically, Arkansas' FirstSource Access-Only claims should be filed on **RED** claim forms and mailed to:

Arkansas' FirstSource
Attn: PPO pricing
P.O. Box 2181
Little Rock, AR 72203-2181

### • Group Cancellation:

Arkansas' FirstSource will no longer accept or price claims for **Pilgrims Pride**, regardless of dates of service. **Pilgrims Pride** cancelled their access-only agreement with Arkansas' FirstSource effective January 1, 2002.

### • Name Change:

Effective June 1, 2002, **American Freightways** changed their name to **FedEx Freight East, Inc.** Employees and dependents in this health plan will have new ID cards. Please use the new name and verify member ID numbers when submitting claims for this group.

## Arkansas State & Public School Employees Mental Health Services:

**Reminder to all facilities & mental health providers:** Please remember to submit all claims for mental health services to CORPHEALTH for processing. Services rendered by a non-participating CORPHEALTH provider will be paid at the out-of-network benefit level. Please send all claims and correspondences to:

CORPHEALTH, Inc.
1701 Centerview Drive, Suite 101
Little Rock, AR 72211

If you would like participation information, please contact CORPHEALTH at (866) 378-16545 or visit the website at www.corphealth.com.

## Biventricular Pacing (Cardiac Resynchronization Therapy):

The FDA has recently approved two new devices for the treatment of patients with congestive heart failure who have intraventricular conduction disorders. These devices are covered when implanted for their FDA labeled indications.

Biventricular pacemakers are covered for patients with congestive heart failure who meet **all** of the following criteria:

1) NYHA Class III or IV;
2) Left ventricular ejection fraction of 35% or less;
3) QRS duration of 130 ms or longer; and
4) Remain symptomatic despite stable, optimal pharmacological therapy.

Implantable cardioverter defibrillator with a biventricular pacemaker is covered for patients with congestive heart failure who meet **all** of the following criteria:

1) NYHA Class III or IV;
2) Left ventricular ejection fraction of 35% or less;
3) QRS duration of 120 ms or longer;
4) Remain symptomatic despite stable, optimal heart failure drug therapy; and
5) Patients who are at high risk of sudden cardiac death due to ventricular arrhythmias including but not limited to those with:
   a) Survival of at least one episode of cardiac arrest (manifested by loss of consciousness) due to a ventricular arrhythmia;
   b) Recurrent poorly tolerated sustained ventricular tachycardia (VT). *The clinical outcome of hemodynamically stable*

*sustained-VT patients is not fully known. Safety and efficacy have not been conducted.*

c) Prior myocardial infarction, left ventricular ejection fraction 35% or less, and a documented episode of nonsustained VT, with an inducible ventricular arrhythmia. *Patients suppressible with IV procainamide or an equivalent antiarrhythmic drug have not been studied.*

At the present time, there is no CPT code that specifically describes these procedures. CPT 33999 should be used for the implantation of the second ventricular lead and should be billed with the appropriate CPT code for dual pacemaker or implantable cardioverter defibrillator.

The use of the unlisted code 33999 will require submission by paper claim and should include the procedure note describing the indications for the use of the device(s). The full coverage policy can be seen by accessing our web site: http://arkansasbluecross.com.

## BlueCard:

### • Automated Duplicate Checking:

To better serve our member, duplicate claims are checked by the claims system and automatically denied when identified, which will reduce unnecessary handling. In order to ensure that corrected claims are not denied, please make sure corrected claims are filed using the "Corrected Claim Form" process described in the article Corrected Bill Submission Form (page 4).

When submitting claims for secondary payment, **do not** file the exact same claim twice. The secondary claim must be filed with the secondary insurance identification number indicated as the ID in the ID number field on the UB-92 or HCFA claim form.

In addition, any claim submitted within 30 days of the first claim will be automatically rejected as a duplicate. Before resubmitting a claim, use the AHIN (Advanced Health Information Network) and/or VRU (Voice Response Unit) systems to verify the current status of the claim.

### • Handle/File Direct Claims:

To improve the process and provide more timely handling of claims that are considered handle/file direct and do not go through the BlueCard system, the following procedures were implemented June 3, 2002.

1) Claims received from providers that indicate a handle/file direct prefix on the identification number will be returned to the provider indicating that the claim must be filed directly to the Home Plan for processing.

2) A letter will be attached to the returned claim indicating the Home Plan's name and address for mailing purposes. The letter also indicates that it should be left attached to the claim when forwarding the claim to the Home Plan. This will provide a clear understanding to the Home Plan as to why the claim was filed direct.

**NOTE:** There will be special circumstances when a Home Plan requests a claim to be handled out of the Blue Card system and the prefix is not indicated on the prefix list. When this occurs, the claim will be forwarded to the Home Plan by ABCBS.

### • Remittance Advice:

Based on feedback from the Provider Workshops, the following improvements and changes have been or are being made to the BlueCard Remittance Advice:

1) Effective with the first remittance advice in June 2002, adjudicated claims on the BlueCard remittance advice are listed in alpha order by patient last name for easier reference.

2) Claims with the message **"the final processing of this claim is pending additional information from the Home Plan"** are listed separately in alpha order by patient last name at the end of the remittance advice.

COMING SOON:
Watch for an insert in your Remittance Advice indicating that these changes have been implemented.

- The remarks code messages printed on the last page of the remittance advice have been revised to provide clearer and more distinct reasons for denials and/or reductions. These changes should be implemented sometime in June 2002. (Attachments, page 9)

## Cardiovascular Education Program:

Arkansas Blue Cross and Blue Shield, Health Advantage and USAble Administrators continue to develop community-based programs with a focus on our members—and your plan of care. As a part of this effort, we are pleased to introduce the **Cardiovascular Education Program**, next in our series of Health Education Programs that are available to our members.

The Cardiovascular Education Program focuses on members who have had medical claims submitted with a diagnosis of ***both*** **hypertension and hyperlipidemia.** These members will receive an invitation to join the program by completing an enrollment form.

Our community-based, disease-specific education programs emphasize self-management techniques, encourage member communication with their physician, include national and local health education resources, and assistance with member health plan benefits.

Program highlights include:

- A voluntary health survey with a customized report based on the member's response.
- One-on-one contact with a regional registered nurse case manager based on the member's response.
- National and local healthcare resource list.
- Mailings from "Close to the Heart™" and "In Charge™" hyperlipidemia and hypertension health education programs, sponsored by Pfizer Pharmaceuticals. (These programs were developed in collaboration with physicians to help patients achieve lifestyle changes in diet, exercise, smoking cessation, weight management and medication—that may lower their risk of heart disease.)

Please contact your local case manager if you treat a member who would benefit from the Cardiovascular Education program or if you have questions regarding the program. Please share any suggestions you have that may improve our community-based efforts. We look forward to working with you on behalf of our members—your patients.

## CHIP Moves to USAble Administrators:

Effective July 1, 2002, the administration of the Arkansas Comprehensive Health Insurance Pool (CHIP) will move to USAble Administrators from Arkansas Blue Cross and Blue Shield. The state of Arkansas has been issuing policies from the Comprehensive Health Insurance Pool since July 1996.

USAble Administrators has signed a three-year contract to administer the CHIP program. Arkansas Blue Cross and Blue Shield is the current administrator of the CHIP fund. Providers should continue to submit electronic claims as usual.

All CHIP insureds were notified by letter in May and have received new ID cards and Schedule of Benefits. The new ID card will provide the correct Member Identification Number to be used in claim submission. Members should mail claims to:

CHIP c/o USAble Administrators
P. O. Box 1460
Little Rock, AR 72203-1460

Beginning July 1, 2002, should you have questions or need more information about CHIP, please contact USAble Administrators at **1-800-285-6477** or at www.usableadminarkansas.com.

## Claims - Timely Filing:

Effective July 1, 2002, the timely filing requirement for ABCBS (PPP and PPO) and Health Advantage will be 180 days. Claims for services incurred July 1, 2002 and after must be filed to ABCBS and Health Advantage within 180 days from the date of the services.

## Corrected Bill Submission Form:

Arkansas Blue Cross and Blue Shield, Health Advantage, USAble Administrators and BlueCard have developed a new form for Arkansas providers when submitting corrected bills. Effective March 1, 2002, the Corrected Bill Submission Form must be completed and attached to all corrected bills for both UB-92 and HCFA claims submitted by Arkansas providers. The purpose of this change is to expedite processing time by assisting in identifying the actual correction and the reason for the correction.

What is a "Corrected Bill"? A "Corrected Bill" is a claim that has been previously submitted to the plan for processing and has been finalized (paid) or denied. A corrected bill must be identified by the words "corrected bill" written on the face of the original claim, and a Corrected Bill Submission Form must be attached to the claim. If a Corrected Bill Submission Form is not attached to the claim, the claim will be returned to the provider unprocessed.

Presently, the Corrected Bill Submission Form can be accessed and printed from the ABCBS web site,

www.arkansasbluecross.com. A copy of the Corrected Bill Submission Form can be found in the March 2002 ***Providers' News***.

We are working toward automating submission of corrected bills for the near future. If you have questions regarding the Corrected Bill Submission Form, please contact Customer Service:

ABCBS: (501) 378-2307 or (800) 827-4814
Health Advantage: (501)-221-3733 or (800) 843-1329
USAble Admin: (501) 378-3600 or (888) 872-2531

## CPT Codes:

### • Category III:

Category III CPT Codes are assigned beginning with 0001T. These are tracking codes for investigational services and are non-covered services. Claims filed for services using Category III codes will be denied.

### • 53850 & 52852 – Allowance:

The PPP allowance for CPT 53850 (Transurethral destruction of prostate tissue by microwave thermotherapy), performed in a non-facility setting, is established at $3,321.37. The allowance for services performed in a facility setting is $845.00.

The PPP allowance for CPT 53852 (Transurethral destruction of prostate tissue by radiofrequency thermotherapy), performed in a non-facility setting, is established at $2,897.92. The allowance for services performed in a facility setting is $882.36.

### • 94760 & 94761 – Discontinuing Payment:

Beginning with the year 2000 Relative Value Units (RVU), Medicare distributed the total Relative Value Units for CPT 94760 (ear oximetry, single determination) and CPT 94761 (ear oximetry, multiple determinations) amongst all other CPT codes and bundled payment for these codes with any other procedure billed on the same day. ABCBS pays for services identified by CPT codes by the Medicare Relative Value Units.

ABCBS will no longer recognize payment for CPT 94760 or 94761 when billed with any other CPT code on the same date of service. CPT 94760 or 94761 will be recognized when billed as a single service provided on a single date.

### • 99000 – Allowance:

Reminder regarding ABCBS and HA allowances for CPT 99000: (Handling and/or conveyance of specimen for transfer from the physician's office to a laboratory.) If CPT 99000 is billed with the same date of service as an Evaluation and Management service or any code in the 10040 – 69999 or 90281 – 99569 range, CPT 99000 is considered bundled into that code and is not separately payable.

**For ABCBS only:** CPT 99000 is a covered service only when billed with a laboratory code (CPT 80048 – 89399) and the specimen is being sent to an outside independent laboratory.

## Digital Mammography:

Full-Field Digital Mammography (FFDM) has been proposed as an alternative to traditional Screen-Film Mammography (SFM). Several digital systems have received FDA approval for screening and diagnosis of breast cancer. The American College of Radiology Investigative Network and the National Cancer Institute are conducting a study of 49,000 women comparing FFDM and SFM but there are no reports yet from this study.

ABCBS benefit contracts with members excludes coverage for any experimental or investigational services. The contract definition of investigational services includes services that are the subject of on-going phase I, II, or III clinical trials to determine efficacy as compared with a standard means of treatment or diagnosis. At this time, digital mammography is a non-covered procedure.

## FEP Update:
## Basic and Standard Options

REMINDER: Effective January 1, 2002, FEP introduced a new plan called **BASIC OPTION**. You can distinguish the type of coverage a person has by the enrollment code located on the front of the identification card.

| **Standard Option** | **Basic Option** |
|---|---|
| Code 104 - Individual | Code 111-Individual |
| Code 105 - Family | Code 112-Family |

The Basic Option (code 111 or 112) is an **in-network only** benefit program. To receive medical benefits, members enrolled in the Basic Option **must** seek care from an **ABCBS FirstSource Preferred provider.** If members are enrolled in Basic Option and seek care

from an ABCBS Participating Provider or a Non-Participating Provider, the member pays all charges.

For medical benefits, members who enroll in the **Standard Option** (enrollment code 104 or 105) have access to the ABCBS FirstSource Preferred Providers, ABCBS Participating Providers, or Non-Participating Providers. However, the member's coinsurance will be less if the member chooses an ABCBS FirstSource Preferred provider.

**Patient needs physical therapy:**

- **Basic Option:** Patient should go to an ABCBS FirstSource Preferred Provider to receive benefits. (Preferred hospital in their area). If the member chooses an independent, non-contracted physical therapist, the member pays all charges.
- **Standard Option:** Patient can choose to go to an ABCBS FirstSource Preferred Provider, ABCBS Participating Provider or Non-Participating Provider to receive benefits. However, the members' coinsurance will be less if the member chooses an ABCBS FirstSource Preferred provider.

**Patient wants admission to the Veterans hospital:**

- **Basic Option:** If the member chooses the Veterans hospital, the member pays all charges. A patient should go to an ABCBS FirstSource Preferred provider to receive benefits. (Preferred hospital in their area)
- **Standard Option:** Patient can choose to go to the Veterans hospital, which is an ABCBS participating provider. The members' coinsurance will be higher if the member chooses an ABCBS Participating Provider or a Non-Participating Provider.

## FEP: Standard Option Guidelines for Submitting Skilled Nursing Facility Claims

**Type of Bill 211, 212, 213 or 214**:
Benefits are limited for Skilled Nursing Facilities under Standard Option plan of the Federal Employee Program. For services rendered in a Skilled Nursing Facility approved by Medicare, Medicare will pay for the 1st through the 20th day in full. From the 21st through the 30th day, FEP will pay the daily coinsurance.

Beyond the 31st day, FEP will pay for 20% of our allowable for the following eligible services up to the total Medicare's coinsurance amount:

1) Eligible drugs that require a prescription by Federal law. Please submit an itemized bill including the prescription names and cost.
2) Physical, Occupational, and Speech therapy performed by a licensed therapist. (A Physical or Occupational therapy assistant/aide is not a FEP covered provider).
   a) Submit the exact dates of service of when each different type of therapy was performed.
   b) Procedure code(s) performed
   c) The name and title of the person performing the therapy.

FEP does have a yearly maximum of 50-visit limitation for Physical Therapy and 25-visit limitation for Occupational/Speech Therapy. The member will be responsible for the difference between our payment and Medicare's coinsurance.

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## Health Advantage: New OPEN ACCESS POS Plan:

In response to customer requests for direct access to network providers and lower-priced health plan, Health Advantage is now offering a new product — Open Access Point-of-Service (OAPOS).

OAPOS is an innovative plan that combines the characteristics of traditional Health Maintenance Organization (HMO) coverage with the extra provider options of a Point-Of-Service (POS) plan. OAPOS provides preventive and routine services with co-payments required for visits to primary care physicians (PCPs).

Members of the OAPOS plan also may visit their in-network specialty physicians without a PCP referral. However, this is where the lower priced health plan becomes apparent with benefit choices of deductibles, co-payments, and co-insurance for specialty and hospital services.

Open Access means that members have choices when visiting health care providers and in using their Health Advantage benefits. Open Access gives members the ability to visit any in-network provider without going through the PCP for a referral and members receive the highest level of benefits available under the in-network benefit program. Members also have the option of using out-of-network providers and receiving the out-of-network benefit coverage.

The OAPOS plan offers:

- In-network deductible — Options include no deductible, $250 in-network deductible, a $500 in-network deductible, or a $1,000 in-network deductible. The in-network deductible is applied to

specialty care physician services, hospital services, maternity services as well as rehabilitation, home health and skilled nursing facility services. This deductible for in-network services is applied after the member pays the applicable co-payment for the services.

- Co-payments — These vary depending on service. Physician co-payment options are $25 or $35. The inpatient admission co-payment is $200 or $500, and the outpatient facility co-payment is $100. Benefit determination requires that co-payments be subtracted first, followed by the deductible and co-insurance.
- Preventive services — PCP services are not subject to deductible.
- Emergency services — The $100 co-payment and co-insurance are not subject to deductible.
- Co-insurance — The in-network options are 20 percent and 30 percent.
- Out-of-network — Out-of-network services are applied after deductibles. The deductible options are $1,000 or $2,000. There is no out-of-pocket limit for out-of-network services.
- Pharmacy – Options include co-payments of $10/$20/$30, $10/$30/$50 and 20 percent co-insurance with co-payments of $10/$30/$50.

For more information, please call Health Advantage at (501) 221-3733 or 1-800-843-1329.

## Ibritumomab Tiuxetan (Zevalin)

Ibritumomab has received FDA approval for the treatment of patients with low-grade B-cell lymphoma who have failed a regimen of standard chemotherapy and a regimen of rituximab. ABCBS will cover Ibritumomab for the FDA approved label indications and will require a copy of the pathology report and documentation that the patient has failed standard chemotherapy including rituximab.

Ibritumomab will be paid by invoice and a copy of the invoice must be submitted with the claim. There is no coverage for:

1) Patients with 25% or greater involvement of the bone marrow by lymphoma and/or impaired bone marrow reserve, as indicated by prior myeloablative therapies (bone marrow or stem cell transplants).
2) Patients with a platelet count less than 100/000 $mm^3$, or neutrophil count less than 1500/$mm^3$.
3) Patients with failed stem cell collection. These are contraindications as listed by the FDA.

## Pegfilgrastim (Neulasta):

Pegfilgrastim is a long-acting neutrophil colony-stimulating factor that is injected once per chemotherapy cycle to decrease the incidence of infection, as manifested by febrile neutropenia, in patients with non-myeloid malignancies. Pegfilgrastim is covered when coverage criteria for filgrastim and sargramostim are met.

The allowance for pegfilgrastim will be based on the invoice price. The invoice must be submitted with the claim.

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## Provider Contracts Updates:

## Contract Deadline:

The Arkansas Blue Cross and Blue Shield re-contracting activity is drawing to a close. Arkansas FirstSource PPO and Health Advantage HMO contracts were to be signed by providers and returned to their respective regional offices by June 1, 2002.

Termination procedures are currently underway for providers and facilities that have not returned their signed contracts. Terminations will be effective July 1, 2002. If you are an Arkansas FirstSource PPO or Health Advantage HMO provider and have not yet returned your signed contract and wish to continue your PPO and HMO participation, please contact your Regional Network Development Representative immediately.

Please note that at this point, it may be impossible to avoid a lapse in your participation status. It is also unlikely that your name will be listed in certain large employer group provider directories published annually in July.

Not all types of participating providers are a part of this contract-updating project. ABCBS is currently addressing the following provider types: Ambulatory Surgery Centers, Chiropractors, CRNAs, Dentists, Hospitals, Optometrists, Physicians (MDs and DOs), Podiatrists, and Psychologists.

## Waivers:

The revised provider contracts contain a provision that allows providers to bill patients for services that are not considered medically necessary or are considered investigational/experimental if the patient has signed a waiver. Historically, these services have been

adjudicated in a manner that required providers to write off these charges. The waiver would allow the provider to bill the patient for these services.

The new contract requires the provider to fully inform the patient that he/she will be financially responsible before the services are rendered. The patient should also sign these waivers before the services are rendered. The waiver language should reflect that the services are not considered medically necessary or are considered investigational /experimental as defined in the member's health plan, and that the patient shall be solely responsible for any charges related to the services.

These waivers should be created on a service-by–service basis and should only be signed in cases that apply; that is, providers should not create a "blanket" waiver that all patients would sign regardless of the services they are receiving. If a proper waiver is not signed or the signature on the waiver in not obtained prior to services being rendered, the provider must write off these charges.

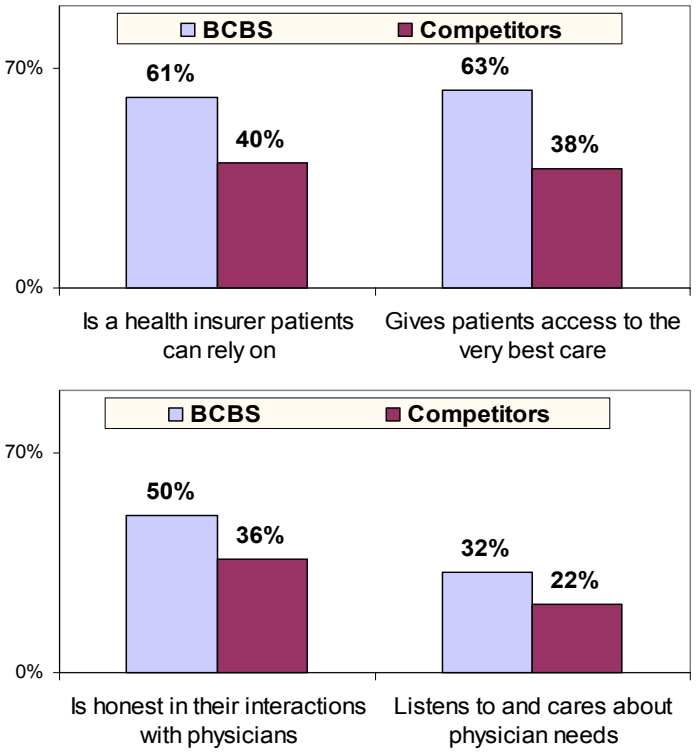
## Physicians See Meaningful Differences Among Health Insurers:

A Blue Cross Blue Shield Association commissioned study by Cooper Research indicates that physicians across the country have a significantly better impression of the "Blues" than of our major competitors. More than one-half (52 percent) of physicians have a positive impression of BCBS (measured by a 7 rating or higher on a 10-point scale), while fewer than a third (31 percent) have a positive impression of prominent national competitors.

However, these positive impressions appear to stem more from the belief that BCBS is customer focused than that it is physician focused. As the chart (page 8) shows, the "Blues" receive substantially higher ratings from physicians for providing patients with reliable insurance and access to quality care than for being honest with physicians or caring about their needs.

These results challenge the notion that physicians uniformly dislike all health insurers because of their role in holding down costs. Instead, they suggest that physicians view the "Blues" differently because of our commitment to reliable, high quality patient care. But they also make clear that the "Blues" could further improve their standing through improved physician relations and greater physician involvement in the way health coverage is provided. For more information, contact Suzette Yun at (312) 297-6550 or suzette.yun@bcbsa.com.

**PHYSICIAN BRAND IMPRESSIONS**
**(Ratings of 7 or Higher on a 10 Point Scale)**




## Treatment of Family Members Ineligible for Coverage:

Services rendered by a provider to a member of his/her immediate family are ineligible for coverage under all Policyholder's Benefit Certificates of Arkansas Blue Cross and Blue Shield, the Federal Employee Program, or Health Advantage. The immediate family can include spouse, parent, child, brother, sister, or legal guardian, by blood, marriage or adoption of the person receiving the services.

**The Providers' News**
The Providers' News is a quarterly publication of Arkansas Blue Cross and Blue Shield. Please send your questions or comments about the Providers' News to:
Karen Green, Editor
Arkansas Blue Cross and Blue Shield
PO Box 2181
Little Rock AR 72203
Email: krgreen@arkbluecross.com

## BlueCard Remarks Codes

| | |
|---|---|
| 0001 | Care prior to coverage effective date |
| 0006 | Dependent not eligible per contract age limit |
| 0009 | Patient not enrolled at time of service |
| 0010 | Care after coverage termination date |
| 0012 | Services not rendered within required time limit per the subscribers contract |
| 0033 | Care was not deemed medically necessary per the subscribers contract |
| 0037 | Anesthesia service rendered by the Surgeon is not covered per the subscriber's contract |
| 0039 | Procedure does not warrant the services of an anesthesiologist per the subscriber's contract |
| 0051 | Procedure does not warrant the services of an Assistant Surgeon per the subscriber's contract |
| 0053 | Original claim processed incorrectly |
| 0055 | Services rendered by relative of patient not a benefit |
| 0067 | Paid in full by other insurance |
| 0070 | This claim cannot be processed until charges processed until charges are filed with other insurance |
| 0085 | File closed until reply to COB Questionnaire is received from subscriber |
| 0106 | These charges are eligible for Medicare |
| 0159 | No Student Certification on file |
| 0188 | No benefits payable when Workers Compensation available |
| 0189 | Duplicate claim previously processed |
| 0205 | Services for diagnosis reported are not a benefit per the subscriber's contract |
| 0213 | Services related to routine or periodic exams are not covered per the subscriber's contract |
| 0230 | Claim received after filing time limit per subscriber's contract |
| 0243 | The annual maximum for these services has been reached per the subscriber's contract |
| 0249 | Maximum number of days has been allowed per the subscriber's contract |
| 0261 | Claim file closed until predetermination obtained by provider |
| 0263 | Required predetermination has been denied |
| 0264 | Medical visits on the day of surgery are not covered per subscriber's contract |
| 0278 | Maternity payable only for subscriber or spouse per subscriber's contract |
| 0291 | Maximum benefits have been provided per subscriber's contract |
| 0347 | Services do not fall within scope of Provider license per subscriber's contract |
| 0421 | This amount was paid under the basic benefits portion of the subscriber's contract |
| 0425 | Expenses not covered under subscriber's contract |
| 0509 | Claim closed until requested information is received from subscriber |
| 0514 | Claim closed until requested information is received from provider |
| 0516 | Claim closed pending receipt of Medicare EOB from subscriber |
| 0531 | Services for pre-existing conditions are not covered per subscriber's contract |
| 0561 | Investigative procedure not a benefit per subscriber's contract |
| 0570 | Coordination of benefits - claim closed - file with other insurance |
| 0706 | No record of membership |
| 0712 | No dependent coverage per subscriber's contract |
| 0740 | Invalid place of treatment for type of procedure performed per subscriber's contract |
| 0745 | Invalid procedure for patients sex type |
| 0749 | This provider is not eligible to bill for these services per subscriber's contract |
| 0756 | Dental coverage only |
| 0762 | Invalid CPT code |
| 0804 | Concurrent care by different physician not a benefit per subscriber's contract |
| 0809 | This service is not covered for this diagnosis per subscriber's contract |

## BlueCard Remarks Codes

| | |
|---|---|
| 0826 | Patient has exceeded the age limit for this service per subscriber's contract |
| 0851 | This procedure is not covered per subscriber's contract |
| 0894 | Benefits are not provided for services obtained from non-participating providers |
| 0947 | Out-of-area non-emergency accident/medical care not covered per subscriber's contract |
| 0969 | Service not covered since illness/injury occurred prior to effective date and the waiting period was not met per subscriber's contract |
| 0992 | Rental charge exceeds purchase price of the durable medical equipment or cost for purchase has been paid on a prior claim |
| 0999 | Condition not covered for this provider type per subscriber's contract |
| 1006 | Benefit covered only if provided or ordered by primary care physician or medical group per subscriber's contract |
| 1027 | Dependent not covered per subscriber's contract |
| 1029 | Blue Shield coverage only |
| 1033 | Blue Cross coverage only |
| 1036 | Inpatient blue cross coverage only |
| 1038 | Services rendered after patient expired |
| 1050 | Misrouted claim |
| 1052 | Maximum lifetime benefits have been provided per subscriber's contract |
| 1053 | Reimbursement for this service is considered to be a portion of another service that has been allowed. Therefore, no payment can be made for this service. |
| 1054 | Payment for this procedure is included in our payment for other services performed on the same day by the same provider |
| 1055 | This provider is not eligible per subscriber's contract |
| 1056 | Services provided prior to date of birth |
| 1057 | This service is ineligible in the reported place of service |
| 1058 | Claim will be processed directly by home plan and provider paid |
| 1059 | Claim will be processed directly by home plan and subscriber paid |
| 1060 | Claim will be processed directly by home plan and Medicare primary |
| 1061 | Claim will be processed directly by home plan - third party liability |
| 1064 | Subscriber may be balance billed |
| 1065 | Policyholder's premiums not paid to date |
| 1067 | Payment has been denied because Medicare did not cover the charges on the claim |
| 1068 | Benefits limited to semi-private room rate |
| 1069 | Provider contracts with home plan. Please submit claim direct with home plan. |
| 1071 | Duplicate service line |
| 1074 | Service is out of network |
| 1075 | This service is not a benefit when billed alone |
| 1076 | Not a benefit under this line of business. Reimbursement to the subscriber will be considered under another line of business. |
| 1077 | This is an ERISA account. Application of state mandate is optional. |
| 1078 | Product not eligible for BlueCard program delivery |
| 1079 | Another insurance carrier handles these services. Please handle directly with other carrier. |
| 1080 | Another insurance carrier handles these services. Please handle directly with the home plan. |
| 1081 | Subscriber has not responded to other coverage inquiry |
| 1082 | Claim denied because this care is the liability of the no-fault carrier. |
| 1083 | Claim submitted under incorrect prefix; update your records for future reference. No additional action on this claim is required from you. |
| 1087 | Claim will be processed directly by home plan |