

## APPENDIX F2

### FAX/MAIL EMC DOCUMENTATION BLUE SHIELD

Blue Shield is pleased to announce that providers can submit claims electronically which require attached documentation. **The Fax/Mail EMC Documentation feature enables providers to submit 100% of their claims electronically.**

Attached are the BLUE SHIELD MEDICAL DOCUMENTATION GUIDELINES. Claims can be filed electronically which include these services and the required documentation faxed or mailed. The specific documentation requirements are listed for each specified service.

If you wish to take advantage of this feature, complete the following steps:

- 1.) Electronic claims which require additional documentation must indicate the method of submission of the documentation (i.e., faxed or mailed) and the postmark or fax transmission date. Submit this information in the following fields in your software. If you are not sure where this should be entered in your system, please contact your software support personnel.

#### **National Standard Format (320 byte) - HA0 record, field 05.0**

ENTER: **FAX DOC MM-DD-YY - if you are faxing the documentation**  
**MAIL DOC MM-DD-YY - if you are mailing the documentation**

- 2.) Complete the appropriate **FAX/MAIL EMC DOCUMENTATION** cover sheet (copy enclosed) for **each** electronic claim for which you are submitting additional documentation. The cover sheet and the documentation must be faxed to the fax number listed on the appropriate cover sheet or mailed to the address listed on the appropriate cover sheet.

Documentation is expected to be received within 2 days of the electronic claims submission if faxed or 5 days if mailed. If an electronic claim is received which requires documentation but the documentation is not received within the designated time frames, the claim will be processed with the information at hand and developed/denied based on claims processing guidelines. If documentation is faxed or mailed but the electronic claim does not reflect the required information or the documentation was not submitted in the method indicated on the electronic claim, the claim will be processed with the information on the EMC claim only and developed/denied based on claims processing guidelines.

If you have any questions, please contact the Provider Automation EMC Helpline at (972) 766-5480.

# BLUE SHIELD DOCUMENTATION GUIDELINES

The following procedures require additional documentation for Regular Business/Managed Care claims processing.

Section I - Documentation for procedures below can be entered in the narrative field:

- **Anesthesia**
  - Modifier, physical status, qualifying circumstances
  - Time
  - (Field with procedure code used by surgeon and the appropriate modifier)
  
- **Modifier 22 - Unusual Services:**
  - Additional information is required which explains why the procedure should be considered over and above routine.
  
- **Not Otherwise Classified Codes (NOC):**
  - Description of charges
  - NDC # if applicable
  
- **Outpatient Chemotherapy/Infusion Therapy**
  - NDC# of drug or Description of Drug
  - Dosage
  - Actual location of drug administration (office or home)
  - Description of open codes
  
- **Radioactive Seeds**
  - Number of Seeds/Wires
  - Location of Seeds/Wires

Section II - The procedures listed below need documentation attachments faxed or mailed at the time the claim is filed electronically. Please indicate in the narrative field whether the information was faxed or mailed and the date.

- **Ambulance - Air/Ground**
  - Mileage
  - Breakdown of charges filed with an open code
  - Trip sheet with H & P/treatment for medical necessity documentation
  
- **Belpharoplasty (Predetermination Is Recommended)**
  - Visual Fields, H & P
  - Pictures
  - (This has to be mailed as faxed visual fields and pictures are not clear)
  
- **Breast Implant Removal & Capsulectomy (Predetermination Is Recommended)**
  - Mammography Report
  - Operative & Pathology Report
  - Physical and History
  - (Predetermination is Recommended for all Breast Surgery)
  
- **Cochlear Device Implantation (Predetermination Is Recommended)**
  - Provide the following information if no predetermination was performed:
    - History & Physical
    - Hearing Test Results
    - Operative Report (Type of device used)
    - X-ray Results
    - Lab Results
  
- **Co-Surgery Surgical Team Charges**
  - Time
  - Statement of Medical Necessity
  - Operative Reports
  
- **Dermatological Multiple Surgeries:**
  - Operative & Pathology Reports
  - H & P/office notes
  - Size of Lesions
  - Number of Lesions

- **Dorsal Column Stimulator Implantation (Predetermination is Recommended)**  
Operative Report  
History and Physical including prior treatment modalities (pharmacological, surgical, physician and psychological therapies) and the results  
Date of last psychological evaluation  
Date of last physical exam
- **Durable Medical Equipment (DME)**  
Physician's prescription  
Description of the equipment  
Estimated length of need
- **Exploratory Lap**  
Operative and Pathology Reports
- **Growth Hormone**  
Fax or Mail the attached Growth Hormone FAX/MAIL Form
- **Home Infusion Therapy**  
National Drug Code (NDC) for all medications  
Procedure 00956 requires units, dosage and frequency of medication  
If billed by a DME Supplier:
  - a. Procedure 00943 requires prescription
  - b. Subcutaneous and IM injections require units, dosage, frequency, plan of treatment and prescription
 Non-routine nursing visits require documentation of visits
- **Lupron**  
H & P/office notes  
Pathology report if diagnosis is Endometriosis  
State size of fibroid if diagnosis is Fibroid Tumor  
Is surgery scheduled?
- **Lysis of Adhesion Charges**  
Operative and Pathology Reports  
History and Physical
- **Multiple Surgeries**  
Operative and Pathology Report  
Anesthesia Report

- **Obesity (Predetermination is Recommended for Surgical Intervention)**
  - Height & Weight of Patient
  - History & Physical describing physical problems resulting from the excess weight; level of functioning; how long patient has been at present level of obesity; number of attempted weight control plans under the supervision of a physician the patient has attempted and the results; and the body frame of the patient (Small, Medium or Large). If surgery is planned in an attempt to relieve the obesity, please state indications for surgical intervention.
  
- **Occupational Therapy**
  - Progress Notes
  - Plan of Treatment
  - Short Term Goals
  - Long Term Goals
  - Evaluation
  
- **Open Coded (NOS) Therapeutic Injections**
  - NDC# if available or name of drug
  - Dosage
  - Statement of Medical Necessity
  
- **Pediatrician Standby Charges**
  - Time
  - Statement of Medical Necessity
  - Labor and Delivery records
  
- **Reduction Mammoplasty (Predetermination is Recommended)**
  - Mammography Report
  - Operative and Pathology Reports
  - History & Physical
  - Pre-op photos (This has to be mailed as faxed photos are not clear)
  - Height and Weight, Bra Size, Body Frame
  
- **Sclerotherapy**
  - Result of the use of elastic stockings
  - Description of the name and size of vessels to be treated
  - Which part of the leg is involved
  - Skin changes such as stasis ulcer or discoloration
  - Pictures of this patient documenting the varicose veins
  
- **Sleep Studies**
  - Documentation supporting Severe Upper Airway Apnea/Sleep apnea
  - H & P/Office Notes
  - Results of Sleep Study

**BLUE SHIELD OF TEXAS**

**REGULAR BUSINESS/MANAGED CARE  
FAX/MAIL EMC DOCUMENTATION COVER SHEET**

**Do Not Write in This Box**

**Claim ICN:**

**To: Medical Suspense & Review  
EMC Medical Documentation  
P.O. Box 660595  
Dallas, TX 75265-0595**

**Fax: 1-800-992-9646  
Fax line available 24 hours a day.**

**Date:** \_\_\_\_\_

**From:** \_\_\_\_\_  
**Physician/Provider Name**

\_\_\_\_\_  
**Provider Number**

**Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Patient's ID#:** \_\_\_\_\_

**Patient's Last Name:** \_\_\_\_\_

**Patient's First Name:** \_\_\_\_\_

**Patient's Middle Initial:** \_\_\_\_\_

**Date of Service on Claim:** \_\_\_\_\_  
**(First From & To Dates of Service on Claim)**

**Total Charge of Claim:** \_\_\_\_\_

**Total Number of Documentation Pages:** \_\_\_\_\_  
**(Include this cover sheet in count)**

**BLUE SHIELD OF TEXAS**

**FEDERAL EMPLOYEE PROGRAM  
FAX/MAIL EMC DOCUMENTATION COVER SHEET**

**Do Not Write in This Box**

**Claim ICN:**

**To: Federal Employee Program  
EMC Medical Documentation  
P.O. Box 660595  
Dallas, TX 75266-0595**

**24 Hour Fax: 1-800-992-9646  
Fax line available 24 hours a day.**

**Date:** \_\_\_\_\_

**From:** \_\_\_\_\_  
**Physician/Provider Name**

\_\_\_\_\_  
**Provider Number**

**Contact:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Patient's ID#:** \_\_\_\_\_

**Patient's Last Name:** \_\_\_\_\_

**Patient's First Name:** \_\_\_\_\_

**Patient's Middle Initial:** \_\_\_\_\_

**Date of Service on Claim:** \_\_\_\_\_  
**(First From & To Dates of Service on Claim)**

**Total Charge of Claim:** \_\_\_\_\_

**Total Number of Documentation Pages:** \_\_\_\_\_  
**(Include this cover sheet in count)**

## GROWTH HORMONE FAX/MAIL FORM

Patient's Name: \_\_\_\_\_

Patient's ID#: \_\_\_\_\_

Height : \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

Age: \_\_\_\_\_

1. Growth rate per year:  
    < age 3 \_\_\_\_\_ cm  
    Age 3 to puberty \_\_\_\_\_ cm  
    Puberty \_\_\_\_\_ cm
2. Stimulated growth hormone (Insulin Clonidine, L-Dopa, Glucagon, Arginine)  
    Maximum \_\_\_\_\_ ng/ml at \_\_\_\_\_ minutes
3. Growth Hormone Releasing Factor (HpGRF) Response Maximum \_\_\_\_\_ ng/ml
4. 24-Hour integrated concentration of growth hormone.  
    Total \_\_\_\_\_ ng/ml  
    Number of Peaks > 10 ng/ml
5. Somatedin C \_\_\_\_\_ >
6. Epiphyses open Y \_\_\_\_\_ N \_\_\_\_\_
7. Bone Age \_\_\_\_\_ years
8. Thyroid Function test results \_\_\_\_\_
9. Additional deficient pituitary hormones.
10. Turner Syndrome confirmed be Karyotype Y \_\_\_\_\_ N \_\_\_\_\_
11. Family history regarding stature.

