

Section 4: Billing and Payment

Blue Shield Hospital and Facility Guidelines

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Section 4: Billing and Payment

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Section 4: Billing and Payment

This section outlines Blue Shield's billing procedures and requirements for submitting claims. It also describes Blue Shield claims payment policies for specific situations, such as coordination of benefits (COB), and explains Blue Shield's process for resolving billing issues.

Claims Submission

Note: Hospitals billing on behalf of physicians should submit claims for physician services using a CMS 1500 electronic format, not on the UB 04 (or successor) form. These services are not contracted under the hospital agreement and, therefore, will be rejected if submitted for payment on the UB 04 (or successor) form.

Real Time Claims Settlement

Real-Time Claims Settlement provides an enhanced provider experience through speed, accuracy and most importantly transparency in the claim's adjudication process. The end goal solution Blue Shield is building toward is an end-to-end automated process from claim creation to payment reconciliation.

Current Enhancements

While we are working to fully automate the transaction process, one of our first steps is the creation of a Real Time Claims Web Tool in Provider Connection. This tool will allow you to estimate and submit claims online to process with a target of 3-9 seconds. While it does take some data entry, it can provide a glimpse of how we are working to speed up the claims adjudication process.

The Web Tool provides two main features:

1. **Claim Estimate:** Providers will have the ability to submit a claim estimate and receive a response with payment assurance for the total payment (including payer payment and member liability amounts) for services. A claim estimate can be submitted up to 7 days prior to services performed and will be valid up to 7 days.
2. **Claim Submission:** Providers will have the ability to submit claims to Blue Shield of California and connect with Blue Shield's processing system for real time adjudication. The finalized claim/payment decision is then presented to the provider. Claims are then paid upon the regular payment cadence.

The Real Time Claims Web Tool is available to registered users on Provider Connection at blueshieldca.com/provider. If you are not a registered user, please see the section *Welcome to Provider Connection* on the home page of blueshieldca.com/provider for instructions on how to register.

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Real Time Claims Settlement *(cont'd.)*

Current Enhancements *(cont'd.)*

Once you are registered on Provider Connection you will need to request access to the Real Time Claims Web Tool via your Account Manager, MSO, or Billing Service. After access is obtained for the Real Time Claims Web Tool it can be opened by clicking *Claims* on the menu bar then clicking *Real Time Claims*.

The Real Time Claims Web Tool is an intuitive system designed with provider ease of use in mind. A resource guide can be found on the Real Time Claims landing page under *Guidelines and resources*. In addition, a reference guide, FAQ documentation, and an eLearning can be found on the Real Time Claims landing page under *News and Education*.

Future State

To further realize our long-term solution, Blue Shield is working to make claims processing automated. These offerings revolutionize how we as an industry process claims and we look forward to continuing to deliver new capabilities in the future. The upcoming claims processing solutions are further defined below.

Blue Shield is working to create a platform for a direct system-to-system connection between providers and Blue Shield. This solution will make it possible for claims to be automatically generated and is intended to help reduce administrative burden on providers. This will be accomplished through a connection with the provider's Electronic Health Records (EHR) system and Revenue Cycle Management (RCM) system to create and send a claim to Blue Shield through a digital connection to be adjudicated in real-time.

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Completing the UB 04 Form

Electronic Submissions

Hospitals and facilities are asked to submit claims electronically that do not have a medical record attached and receive remittance electronically or via web/automated solution for faster and more efficient claims processing. Electronically submitted claims will be acknowledged within 2 days. Refer to the HIPAA ANSI Implementation Guides, the National Uniform Billing Committee (NUBC) UB 04 Data Element Specifications, and the Blue Shield 837 Transaction Companion Guide for detailed instructions on electronically submitted claims. For specific guidelines, refer to Blue Shield's 837 Companion Guide found on Provider Connection at blueshieldca.com/provider.

For information on electronic submissions, go to Provider Connection, call the Electronic Data Interchange (EDI) Help Desk at (800) 480-1221 or email EDI_BSC@blueshieldca.com. Hospitals and facilities may submit claims online through our vendor Office Ally. To learn more about Office Ally, go to Provider Connection at blueshieldca.com/provider, click on *Claims, Manage Electronic Transactions, and how to enroll in EDI*.

To ensure efficient processing, Blue Shield **may** require additional information for the following types of claims. We require all claims be submitted through your electronic connection and only submit on paper with additional documentation if the claim suspends processing or is denied for additional information.

- Exception Claims,* including, but not limited to:
 - Stop-Loss
 - Implants
 - Trauma
 - Transplants
- Medicare supplement claims
- Other Organ transplant claims
- Claims for inpatient admissions with covered and non-covered days during the same stay
- Late discharge (Documentation of medical necessity must be attached to the claim form.)

**This list of claims is not all-inclusive. For all exceptions, please refer to your hospital contract.*

Section 4: Billing and Payment

Claims Submission (*cont'd.*)

Completing the UB 04 Form (*cont'd.*)

Providers should transmit their National Provider Identifier (NPI) in the billing provider segment of each claim along with their tax ID. Blue Shield will reject claims that do not contain this information. For specific information on where to input the NPI in the electronic format, providers may call the EDI Help Desk at (800) 480-1221, email EDI_BSC@blueshieldca.com or visit Provider Connection at blueshieldca.com/provider.

Paper Submission

For faster processing and turnaround, please submit all claims electronically. When paper claims forms must be used, Blue Shield requires accurately completed UB 04 (or successor) forms to process claims quickly and efficiently. Paper claims will be acknowledged within 15 days. Blue Shield utilizes Optical Character Recognition (OCR) which allows paper claims to be scanned and data interpreted with minimal data entry. Claims submitted on photocopied claim forms prevent the OCR process from working properly, necessitating manual data entry of the claim, which can slow processing and payment. To facilitate the efficient and accurate claims processing of paper forms, original red claim forms are required. Also, ensure:

- Data entered onto the claim form is done in Arial font, point size 10–12
- Only black ink is used
- Data is entered in CAPITAL letters
- Dot matrix printers are not used. Laser printers are recommended.
- No italics, red ink, stickers or rubber stamps are used
- No handwritten descriptions are placed on the claim
- No narrative descriptions of procedure, modifier or diagnosis are on the claim. The CPT, Modifier, ICD-10-CM, or ICD-10-PCS codes are sufficient. For drug codes, the CPT and NDC are required.
- No white correction fluid is used
- Data is not touching box edges
- No special characters are used (e.g., dollar signs, punctuation marks, parentheses)
- NPI is required for providers submitted on paper claims.

Please refer to the *California UB 04 Billing Procedures Manual*, available from the California Healthcare Association, for detailed instructions on this form.

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Claims Submission *(cont'd.)*

UB 04 Form Locators

Each field on the UB 04 (or successor) form is called a “form locator.” The following form locators merit special attention:

Provider Name and address (Form Locator 1) – Submit the physical address, Provider Name, address line 1, address line 2, provider city, provider state, and provider zip code.

Provider Name and address (Form Locator 2) – Required if the pay to address is different than physical address, provider name, address, provider city, provider state, and provider zip code.

Type of Bill (Form Locator 4) – Submit the type of bill. Note: This is a four-digit alphanumeric code. The 4th digit indicates the sequence of the bill in the episode of care and is referred to as a “frequency” code. If the 4th digit is billed as 0 (zero), the claim is defined as a “Nonpayment/Zero Claims” and will not be considered for payment.

Tax ID (Form Locator 5) – Submit the Federal Tax ID of the facility.

Statement Covers Period (Form Locator 6) – Enter the dates of service that correspond to the charges. Do not enter billing or posting dates. This includes outpatient claims.

Name on Baby’s Claim (Form Locator 8a) – When submitting a separate claim for a level two, three or four NICU newborn, enter the baby’s name rather than “baby boy” or “baby girl.” In the case of twins, indicate the baby’s name rather than “Baby A” or “Baby B.” Blue Shield will return the unprocessed claim if the baby’s name is missing.

Patient’s Address (Form Locators 9a-d) – Submit the Patient’s address, city, state and zip code.

Patient Date of Birth (Form Locator 10) – Submit the Patient’s date of birth.

Sex of Patient (Form Locator 11) – Submit the sex of the patient.

Admission Date (Form Locator 12) – Submit the date the patient was admitted, this includes outpatient claims.

Type of Admission (Form Locator 14) – Submit the Type of Admission.

Source of Admission (Form Locator 15) – Submit the Source of Admission.

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Claims Submission *(cont'd.)*

UB 04 Form Locators *(cont'd.)*

Maternity Claims – Charges for the mother and **level one NICU** baby should be billed together, either on the same claim or at the same time. However, if the baby requires placement in a level two, three, or four Neonatal Intensive Care Unit (NICU) room (Revenue Code 172, 173, or 174, respectively), separate claims should be submitted for the mother and baby.

Note: For network hospitals with negotiated per diem/case rates, only one per diem/case rate will be paid for both the mother and baby, except when the baby requires placement in level two, three or four NICU or if the baby is in a level one NICU after the mother's discharge.

Discharge Hour (Form Locator 16) – Inpatient Claims – Late Discharge – Only medical necessity justifies an additional half-day or full-day charge on the day of discharge. Documentation of medical necessity must be attached to the claim form.

Subscriber Information (Form Locator 38) – Submit the subscriber's name, address, city, state, and zip code. Do NOT enter Blue Cross or Blue Shield P.O. Box 1505, Red Bluff, CA address. The subscriber address should be submitted in this field.

Covered Days (Form Locators 39-41) – Submit the number of Covered Days as a value code (Qualifier 80).

Non-Covered Days (Form Locators 39-41) – Submit the number of Non-Covered Days as a value code (Qualifier 81).

Coinsurance Days (Form Locators 39-41) – Submit the number of Coinsurance Days as a value code (Qualifier 82).

Lifetime Reserve Days (Form Locators 39-41) – Submit the number of Lifetime Reserve Days as a value code (Qualifier 83).

Revenue Codes (Form Locator 42) – Submit valid Revenue Code for the services provided. Blue Shield will deny charges billed with invalid Revenue Codes.

Note: Certain billing scenarios may require Blue Shield to apply billed charges to Revenue Code 249. In some billing scenarios, Blue Shield may add Revenue Code 249 to identify combined or non-payable charges.

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Claims Submission *(cont'd.)*

UB 04 Form Locators *(cont'd.)*

HCPCS Codes (Form Locator 44) – Submit valid HCPCS and appropriate modifier, rate or HIPPS Code for the services provided. Blue Shield encourages the use of modifiers in accordance with the National Uniform Billing Committee and the *California UB 04 Billing Procedures Manual*, as modifiers more accurately define the service(s) provided.

Note: If a deleted HCPCS Code is submitted and has been replaced by a single procedure code, then the procedure code will be recoded to the valid replacement code. If the HCPCS Code cannot be mapped to a single valid procedure code because there is either no replacement code or a one-to-many replacement code mapping for the deleted code, the procedure will be denied as a deleted procedure code.

Service Date (Form Locator 45) – When billing for outpatient services and the “Statement Covers Period” (Form Locator 6) spans multiple dates, each service must be entered on a separate line with the actual date of service performed.

Multiple room and board individual dates of service are needed to process inpatient claims within Form Locator 45 or on the itemization.

Note: For network hospitals with negotiated per diems, additional payment for late discharges cannot be made under the terms of your contract.

Outpatient Charges and Multiple Inpatient Room & Board Charges must identify the date on each service line.

Number of Services Performed (Form Locator 46) – Submit the Number of Services provided for each revenue code.

Billed Charges (Form Locator 47) – Submit the Billed Charges for the service performed.

National Provider Identifier – NPI (Form Locator 56) – Enter the Billing Provider NPI number.

Other PRV ID (Form Locator 57) – Enter the Blue Shield Provider Identification Number (PIN), including the alpha prefix and suffix.

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Claims Submission (*cont'd.*)

UB 04 Form Locators (*cont'd.*)

Coordination of Benefits (Form Locators 58-65) – When more than one insurance carrier is involved, enter complete information regarding the primary, secondary, and other carriers and members. Indicate the other insurance carrier's name, address and policy number in the "Remarks" section. Also include any payment information, if known. When Blue Shield is the secondary payor, attach a copy of the primary carrier's remittance advice or EOB. Also attach a copy of the other insurer's identification card, if available.

- If other insurance is indicated:
 - Line A – Enter the Primary Carrier information.
 - Line B – Enter the Secondary Carrier information.
 - Line C – Enter the Tertiary information.
 - COB claims can be received electronically up to Tertiary. Blue Shield follows CMS guidelines. For facility inpatient claims, the COB is submitted at the claim level. For facility outpatient and professional claims, the COB is provided at the line level adjudication. For specific guidelines refer to Blue Shield's 837 Companion Guide found on Provider Connection at blueshieldca.com/provider.

Pre-admission Number (Form Locator 63) – Enter the reference number that Blue Shield issues to track pre-admission information. For Access+ HMO and POS patients, enter both the Blue Shield tracking number and the reference number provided by the patient's IPA/medical group, if applicable. For emergency room visits, enter the name or license number of the authorizing physician, if the patient's primary care physician referred or approved the admission.

Principal Diagnosis / Other Diagnosis (Form Locators 67 A-Q) – Enter all the diagnosis codes using the current ICD-10-CM Manual for accurate coding. All diagnoses must be coded to the highest level of specificity. The final diagnosis **must** appear on all claims. The admitting diagnosis is sufficient on interim claims. If no diagnosis is indicated, Blue Shield will be unable to process the claims; if no diagnosis is indicated on an electronic claim, it will be rejected. The Present on Admission (POA) indicator must be assigned to principal and secondary diagnoses (as defined in Section II of the *ICD-10-CM Official Guidelines for Coding & Reporting*) on all inpatient acute care facility claims.

DRG Code (Form Locator 71) – Enter the appropriate DRG Code.

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

UB 04 Form Locators *(cont'd.)*

External Cause of Injury (Form Locators 72 a-c) – Inpatient acute care facility claims must contain the External Cause of Injury (ECI) ICD-10-CM Code, along with the POA indicator, when an injury, poisoning, or adverse effect occurs during the medical treatment.

Principal Procedure / Other Procedure (Form Locators 74 a-e) – ICD-10-PCS procedure codes are the standard code set for inpatient facility procedures. Facilities may capture the ICD-10-PCS procedure codes for internally tracking or monitoring facility outpatient services; however, when submitting claims, facilities must use HCPCS Codes and the appropriate modifier to report outpatient services at the service line level and the claim level, if the situation applies.

Electronic Claim Principal Procedure:

Even though an ICD-10-PCS procedure code qualifier is available, the Transactions and Code Sets regulation state that in addition to a HCPCS code qualifier, at the “situational” claim level segment, ICD-10-PCS procedure codes are the adopted standard code set for facility inpatient services.

Attending Physician (Form Locator 76) – Enter the name and NPI of the attending physician. Both name and NPI are required.

Operating Physician (Form Locator 77) – Enter the name and NPI of the operating physician.

Other Physician (Form Locator 79) – Note: Facilities rendering services to a Blue Shield POS member who has self-referred must enter the words "self-referral" in this form locator for Blue Shield to accurately identify and process the claim under the PPO benefit plan coverage.

Electronic Claim Record of Referring Physician:

Last Name Field (Claim Header Record) – Enter SELFREFERRAL

First Name Field (Claim Header Record) – Leave Blank

Taxonomy Code (Form Locator 81) – Enter the GENERIC NPI = 1002233777 with qualifier “B3”.

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Claims Submission *(cont'd.)*

Other Required Billing Information

Outpatient Charges – Submit outpatient claims electronically or on the UB 04 (or successor) claim form if medical records are attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Use appropriate Revenue, CPT/HCPCS Codes and modifiers for the following outpatient services:

- Surgical Services
- Emergency Services and Urgent Care Services
- Dialysis Services
- Infusion Therapy Services
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Respiratory Therapy
- Radiology/Pathology/Diagnostic Tests
- Clinical Laboratory Services
- Pharmaceutical Services
- All Other Outpatient Services

Enter the codes in Form Locator 44. Be sure to include all applicable Revenue, CPT/HCPCS Codes and modifiers. Refer to Appendix 4-A: Reimbursement for Outpatient Services, for reimbursement details around each outpatient service. In accordance with national billing guidelines, Blue Shield requires the use of detailed, specific codes instead of generic, general codes.

Professional Charges – Facilities that act as the billing agent for hospital-based physicians (i.e., emergency room physicians, clinic physicians, anesthesiologists, radiologists, pathologists, etc.) and other allied health professionals must obtain a separate nine-digit Blue Shield professional provider identification number (PIN) for both group and individual providers to bill for these services. Services billed using Revenue Code 096X – 098X, CPT Codes with Modifier 26, and professional-only CPT Codes, will be denied if billed on the UB-04 (or successor) claim form.

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Other Required Billing Information *(cont'd.)*

Global CPT Codes – As noted above, Blue Shield does not pay for professional charges; accordingly, a global CPT Code should not be used when a technical component-only CPT Code is available. In the event a global CPT Code is billed, and a technical component-only CPT Code is available, the global CPT Code will be recoded to the technical component-only CPT Code and reimbursement will be determined based on the technical component-only CPT Code.

Facility Fees for Professional Office Visit Services – Blue Shield does not reimburse or pay facilities for clinic facility charges billed under Revenue Codes 510-529. Reimbursement for facility fees associated with office services is included in the physician professional fee and is not paid separately to facilities.

Skilled Nursing Facility Charges – Hospital and free-standing skilled nursing facility services must be billed on the UB 04 (or successor) claim form with the appropriate Revenue Code and CPT/HCPCS Codes to indicate the level of care or identified excluded service.

Dialysis Charges – Free-standing dialysis center services must be billed electronically or on the UB 04 (or successor) claim form if medical records are attached with the appropriate Revenue Code, CPT/HCPCS Codes and modifiers, in order to receive payment for services rendered. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Facilities must submit claims electronically for professional charges or on a CMS 1500 claim form if medical records are attached and must include not only the billing agent NPI, but also the NPI of the provider who performed the service. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Block 24J of the CMS 1500 Form or the rendering provider field of the electronic record format is the appropriate location for showing the rendering provider NPI. Please note that for Blue Shield Medicare Advantage claims, the rendering physician's state license or UPIN must be entered in this field.

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Reference Materials

In addition to the *California UB 04 Billing Procedures Manual* and the NEIC or NUBC Specification Manual, other reference materials are available to ensure appropriate coding. Various types of codes used in submitting claims are listed below.

Revenue Codes – Codes that identify a specific accommodation or ancillary service and used to determine payment. For appropriate coding and specific information about revenue codes, please refer to the *California UB 04 Billing Procedures Manual*.

Note: Certain billing scenarios may require Blue Shield to apply billed charges to Revenue Code 249. In some billing scenarios, Blue Shield may add Revenue Code 249 to identify combined or non-payable charges.

ICD-10-CM (Clinical Modification) – The ICD-10-CM List contains categories, subcategories and codes. Characters for categories, subcategories and codes may be either a letter or a number. All categories are 3 characters. A three-character category that has no further subdivision is equivalent to a code. Subcategories are either 4 or 5 characters. Codes may be 3, 4, 5, 6 or 7 characters. That is, each level of subdivision after a category is a subcategory. The final level of subdivision is a code. Codes that have applicable 7th characters are still referred to as codes, not subcategories. A code that has an applicable 7th character is considered invalid without the 7th character.

ICD-10-PCS (Procedure Coding System) – ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification (e.g., the fifth axis of classification specifies the approach in sections 0 through 4 and 7 through 9 of the system).

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Reference Materials *(cont'd.)*

CPT (Current Procedural Terminology) Codes – Five-digit codes for identifying medical services and procedures performed by physicians. The American Medical Association publishes the *CPT Code Manual*. Use this document when billing for the following types of services:

- Surgical Services
- Occupational Therapy
- Emergency Services and Urgent Care Services
- Speech Therapy
- Dialysis Services
- Respiratory Therapy
- Infusion Therapy
- Radiology/Pathology/Diagnostic Tests
- Immunizations
- Clinical Laboratory Services
- Physical Therapy
- All Other Services

HCPCS Level II – Standardized coding system that is used primarily to identify products, supplies, and services not include in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics and supplies when used outside a physician office. Appropriate HCPCS Codes should be used to bill for outpatient pharmaceuticals including units of service based upon the HCPCS Code description.

NDC (National Drug Code) – 10- or 11-digit universal drug product identifier found in the *Red Book*, the *Blue Book*, or the *National Drug Code Directory*. When billing for drugs, supplies, and equipment, use HCPCS and NDC codes. NDC Codes are required for new drugs without an assigned HCPCS Code, for these services facilities must bill using the appropriate Revenue Code, unclassified J-Code (HCPCS) and the NDC Code with description in order to receive payment.

The billing document should include the following information:

- Name of patient
- Date of service
- Drug name
- Drug strength
- NDC Number and quantity

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Claims Submission *(cont'd.)*

Reference Materials *(cont'd.)*

Please refer to the HIPAA ANSI Implementation Guide and Blue Shield of California 837 Transaction Companion Guide for submitting claims electronically.

AWP – AWP refers to the Average Wholesale Price of pharmaceuticals dispensed per NDC Code as set forth in a nationally-recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

ASP– ASP refers to the Average Sales Price is a market based price that reflects the weighted average of all manufacturer sales prices that includes all manner of discounts. The ASP is issued by CMS quarterly based on the information submitted by the manufacturer and is a reference point to estimate acquisition costs.

Medicare Crossover

Claims for Blue Shield Medicare Supplement plans are automatically sent to Blue Shield by the Medicare carrier. Providers do not need to submit these claims to Blue Shield for supplemental coverage processing.

Please check your Medicare Remittances for notification that your original claim has been crossed over to ensure that you do not send any duplicate claim to Blue Shield of California. If it has crossed over and you have not received a remit within 30 days, please check claim status with the appropriate Blue plan and then re-submit electronically with the local Blue plan if necessary.

When Blue Shield is the patient's secondary carrier, submit claims electronically using the process below or contact your clearinghouse or billing system vendors for EDI Medicare secondary submission. If EDI secondary is not available, attach a copy of Medicare's RA to the back of the UB 04 (or successor) or CMS 1500 form even if the remittance advice indicates a complete denial of payment by Medicare.

Claims for Blue Shield Medicare Supplement plans are automatically sent to Blue Shield by the Medicare carrier. Providers do not need to submit these claims to Blue Shield for supplemental coverage processing.

Please check your Medicare Remittances for notification that your original claim has been crossed over to ensure that you do not send any duplicate claim to Blue Shield of California. If it has crossed over and you have not received a remit within 30 days, please check claim status with the appropriate Blue plan and then re-submit electronically with the local Blue plan if necessary.

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Medicare Crossover *(cont'd.)*

When Blue Shield is the patient's secondary carrier, submit claims electronically using the process below or contact your clearinghouse or billing system vendors for EDI Medicare secondary submission. If EDI secondary is not available, attach a copy of Medicare's RA to the back of the UB 04 (or successor) or CMS 1500 form even if the remittance advice indicates a complete denial of payment by Medicare.

Instructions for COB Electronic Submission

837 Professional COB Claims – Secondary/Tertiary Electronic Claims to Blue Shield

- Claim level information can be submitted, Blue Shield requires line level on professional claims
- Standard list refers to HIPAA compliant codes established by CMS and other government entities
- Both 2430 segments must equal original total charge in CLM02 in order to balance

Claim Information (2300)

CLM*TERT837PDLLRSNDTST*1000***23>>1*Y*A*Y*Y*B~

837 Institutional COB Claims – Secondary/Tertiary Electronic Claims to Blue Shield

- Claim level information needs to be submitted, Blue Shield may also receive line level on COB institutional claims.
- Standard list refers to HIPAA compliant codes established by CMS and other government entities.
- Both 2430 segments must equal original total charge in CLM02 in order to balance.

Claim information (2300)

CLM*COBSECTERTST*11751.32***11A>1*Y**Y*Y*****Y~

Section 4: Billing and Payment

Claims Submission *(cont'd.)*

Medicare Crossover *(cont'd.)*

Instructions for COB Electronic Submission *(cont'd.)*

CAS Claim Level Adjustments: (Select one of the following): (Loop 2320)

- CO Contractual Obligations
- CR Correction and Reversals
- OA Other Adjustments
- PI Payor Initiated Reductions
- PR Patient Responsibility

CAS02 Claim Adjustment Reason Code: (Use appropriate adjustment reason codes)

Examples:

1 = Deductible Amount

2 = Coinsurance Amount

3 = Copayment Amount

Examples

CAS*PR*1*9*7.93~

CAS*OA*93*15.06~

Note: Claim Adjustment Reason Codes are available via Washington Publishing at <http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/>.

Contact the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com with any questions about Medicare supplemental claims that should have been forwarded but were not. Questions about the amount paid on the supplemental claim should be directed to the appropriate Blue Shield Customer Service department.

Section 4: Billing and Payment

Claim Attachments

Coordination of Benefits (COB) Documentation

When Blue Shield is the patient's secondary carrier, submit claims electronically using your vendors EDI secondary process. For more information, see Blue Shield instructions for secondary COB electronic submission in the Medicare Crossover section or contact the EDI Help Desk at (800) 480-1221.

If EDI secondary is not available, attach proof of the primary carrier's payment or denial and a copy of the other carrier's identification card (see Coordination of Benefits information further in this section).

Detail of Charges

Occasionally, Blue Shield may contact providers for an itemization of charges (e.g., exception claims). In those instances, prompt cooperation will expedite the payment process.

Emergency Room Visits

A copy of the emergency room report is required to be submitted upon Blue Shield's request.

Hospital-Acquired Conditions / Never Events Documents

A copy of the medical record and an itemization of charges must be submitted with acute care hospital claims for inpatient admissions during which there was a Hospital-Acquired Condition (HAC) or Never Event (see Hospital-Acquired Conditions / Never Events information in this section).

Medicare Secondary

Please check your Medicare Remittances for notification that your original claim has been crossed over to ensure that you do not send any duplicate claim to Blue Shield. If it has crossed over and you have not received a remit within 30 days, please check claim status with the appropriate Blue plan and then resubmit electronically with the local Blue plan if necessary.

For more information, see Blue Shield instructions for secondary COB electronic submission in the Medicare Crossover section or contact the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

If EDI Medicare secondary is not available, attach a copy of Medicare's RA to the back of the UB 04 (or successor) or CMS 1500 form even if the remittance advice indicates a complete denial of payment by Medicare (see the Medicare Non-Duplication of Coverage information in this section).

Section 4: Billing and Payment

Claims Processing Logic and Payment Policies

The following provides a high-level, general overview of Blue Shield's payment processing logic. Please refer to Provider Connection at blueshieldca.com/provider under the *Claims* tab for the full payment policies. Please call Provider Information & Enrollment at (800) 258-3091 for additional information.

Blue Shield Claim Edits and Industry Standard Correct Coding

Blue Shield utilizes claims editing software that uses correct coding from industry standard sources, such as Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and health plan-developed policies, as applicable, during the claims adjudication process. Additional sources may be used as defined in the Claim Editing Payment Policy.

The claims editing software is also able to identify previously submitted historical claims that are related to current claim submissions, which may result in adjustments to claims previously processed.

Claims editing software will be updated periodically, without notification, to reflect the addition of newly released/revised/deleted codes and their associated claim edits, including but not limited to NCCI revisions, and health plan payment policies.

Prescreen Claims

Blue Shield provides web access to Clear Claim Connection, a tool that enables providers to prospectively prescreen claims. Access and training instructions for Clear Claim Connection can be found on Provider Connection at blueshieldca.com/provider under *Claims*, then *How to submit claims*.

Payment Policies

Blue Shield has adopted payment policies for licensed facility provider types. Blue Shield Payment Policies are updated periodically to reflect the addition of newly released/revised/deleted codes without notification and can be found on Provider Connection at blueshieldca.com/provider under the *Claims* tab.

Out of Sequence (Split Claims)

Denial of payment for "out of sequence" claims arises when two or more procedures with the same date of service that would have resulted in a denial of one of the procedures (e.g. mutually-exclusive procedures; component procedures to others) are submitted by the provider out of sequence on different dates.

Section 4: Billing and Payment

Special Billing Situations

Billing of Exchange-Purchased Plans

Under California and federal law, subscribers receiving subsidies for Exchange-purchased individual plans that are delinquent in premium payments have a three-month grace period to pay all outstanding premiums due. During the first month of this grace period, Blue Shield will continue to process all appropriate claims for services rendered to the subscriber and any dependents. During the 2nd and 3rd months of the grace period, coverage for the subscriber and dependents is suspended until all outstanding premiums are paid to Blue Shield. When premiums become delinquent and the member is in the 2nd or 3rd month of the grace period, Blue Shield will provide written notification to providers advising them that the member's eligibility has been suspended. In the event that premiums are not received by the end of the subscriber's three-month grace period, claims will be denied.

Coordination of Benefits (COB)

Coordination of Benefit (COB) claims should be received electronically up to Tertiary. Blue Shield follows CMS guidelines. For facility inpatient claims, the COB is submitted at the claim level. For facility outpatient and professional claims, the COB is typically provided at claim line level. Please see instructions for COB electronic submission on pages 10-11 of this document or refer to Blue Shield's 837 Companion Guide found on Provider Connection at blueshieldca.com/provider.

Electronic Data Interchange Transaction Set Implementation Guide Drug Requirements

837 Institutional Claims

Home infusion services and drug claims must be billed on the 837 institutional electronic claims transaction using the following guidelines:

- Report name of the drug in the claim note (Loop 2300 NTE02). Use "MED" in NTE01.
- Report description using up to 80 bytes, placed in order of the service lines (See example below).
- Report HCPCS code of drug at the service line (Loop 2400 SV202-2). Use "HC" in SV202-1.
- Report date of service in the service line (Loop 2400 DTP03). Use "472" in DTP01.
- Use qualifier "N4" for NDC format 5-4-2 (Loop 2410 LIN02).
- Report the national drug code (Loop 2410 LIN03).
- Refer to the 5010 837 Institutional Guide, pages 43-44, for more information.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Notes:

2072300 NTE01 Note reference - "MED" is Medications.

2072300 NTE02 Description - Name of drugs. Use up to 80 bytes and show in order of service lines.

Example:

*(NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).*

A new field is available in 5010 for description of services that can be used for drug specifics or any additional information needed for the claim. The NTE segment can also still be utilized.

Examples:

Professional Claim / SV102-7

*SV1*HC>J3490>>>>MULTITRACE-4 10ml Conc.*11.94*UN*1.000***1~*

Institutional Claim/ SV202-7

*SV2*0821*HC>90999>G4>V6>>>NON-SPECIFIC PROCEDURE CODE*2785*UN*1~*

End Stage Renal Dialysis (ESRD) Hospital (Medicare)

ESRD claims are paid based on the End Stage Renal Dialysis Prospective Payment System (ESRD PPS).

ESRD PPS payment is based on the following factors; through date, date of birth, condition code 73 or 74, value code A8 and A9/value code amounts, revenue code, patient's height and patient weight to be able to determine the correct payment. Refer to the *Medicare Claims Processing Manual Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims*.

Genetic and Molecular Testing

A procedure description is required for Unlisted Genetic and Molecular Testing procedure codes with use of the Genetic Testing Unit (GTU). The specific GTU for each procedure code can be identified by accessing Concert Genetics Provider Portal at www.concertgenetics.com/join-blue-shield-california. Providers are required to bill according to the CPT coding established in the Concert Genetics portal.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Claim Type	Field or Segment	GTU Format
837I Transaction [Institutional Claims]	Loop 2400 segment SV202-7	Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: <ul style="list-style-type: none">• 6V98G• GTU-6V98G
UB-04 Form [Institutional Claims]	Form Locator 80	

Home Health (Medicare)

For faster processing and turnaround, please submit all claims electronically. Services requiring medical records must be billed on the CMS 1500 / UB04 (or successor) claim form.

Providers accepting Medicare rates are paid at the Home Health Prospective Payment System (HHPPS).

The following items must be included in order to determine the correct Medicare payment:

- The Episode Timing
- Severity Points
- HIPPS Codes billed with Revenue Code 0023 with zero billed amounts on the line

Refer to the *Medicare Claims Processing Manual Chapter 10 – Home Health Agency Billing*.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Hospice Billing (Commercial)

Hospice is a type of care that focuses on the palliative care of a terminally ill patient's pain and symptoms. Terminal illness is defined as a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

Authorization

All hospice services require prior authorization.

- HMO Plans – Authorization through the delegated IPA or medical group.
 - Direct Contracting IPA– Authorization through Blue Shield's Medical Care Solutions Department.
- PPO Plans – Authorization through Blue Shield's Medical Care Solutions Department.

Billing of Covered Services

For faster processing and turnaround, please submit all claims electronically. Services requiring medical records must be billed on the CMS 1500 / UB04 (or successor) claim form with the appropriate Revenue Code, Type of Bill, CPT/HCPCS Codes and modifiers in order to receive payment for services rendered.

When billing for hospice care, claims should have Type of Bill (TOB) 81x or 82x and the following revenue codes:

- 651 – Routine home care
- 652 – Continuous home care
- 655 – Inpatient respite care
- 656 – General inpatient care
- 657 – Physician care

For hospice arranged services, the provider of service will bill the hospice and the hospice will reimburse the provider. The hospice will then include those services in the billing to Blue Shield. Blue Shield will reimburse the hospice for all covered services based on the contracted rates.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Hospice Billing (Commercial) *(cont'd.)*

Consultation Visit Prior to Hospice Care

The hospice will bill a consultation visit prior to hospice care services using HCPCS G0337 – Hospice Evaluation and Counseling Services, Pre-election.

Please call Provider Services & Enrollment at (800) 258-3091 for additional information or for answers to questions not addressed above.

Hospice Billing (Medicare)

CMS issued Program Memorandum Intermediaries/Carriers – AB-02-015 (2/7/02) CMS Pub. 60AB *Clarification of Payment Responsibilities of Fee-for-Service Contractors as it Relates to Hospice Members Enrolled in Managed Care Organizations (MCOs) and Claims Processing Instructions for Processing Rejected Claims* to clarify regulations regarding payment responsibility for hospice patients enrolled in managed care plans, as well as provide specific claims processing requirements to ensure payment for such claims. The information below is reprinted from that program memorandum:

Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a provider treating an illness not related to the terminal condition or an MA to a fee-for-service contractor of CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. HMO monthly capitation payments will begin on the first day of the month after the beneficiary has revoked his or her hospice election.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Hospice Billing (Medicare) *(cont'd.)*

Billing of Covered Services

Medicare hospices will bill the RHHI for Medicare beneficiaries who have coverage through managed care just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial hospice benefit period, and followed by claims with types of bill 81x and 82x. If the beneficiary later revokes election of the hospice benefit, a final claim indicating revocation, through use of Occurrence Code 42, should be submitted as soon as possible so that the beneficiary's medical care and payment are not disrupted. Occurrence Code 42 cannot be used in situations where the beneficiary is transferred from one hospice provider to another. The HMO may directly bill Medicare carriers for attending physician services, as listed above, in keeping with existing processes.

Medicare physicians may also bill such service directly to carriers if all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were recently set forth in Transmittal 1728, Change Request 1910 of the *Medicare Carriers Manual* (MCM), Part 3, effective April 2002 and specifies use of Modifiers GW and GV. When these modifiers are used, carriers are instructed to use an override code to assure such claims have been reviewed and should be approved for payment by the Common Working File (CWF) in Medicare claims processing systems.

For medical services for a condition not related to the terminal condition for which the beneficiary elected hospice, a claim must be submitted to the intermediary using the condition code 07. If physician services are billed to carriers, the instructions in Transmittal 1728, Change Request 1910 of the MCM should be followed and should specify the use of Modifier GW.

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice is revoked.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Hospice Billing (Medicare) *(cont'd.)*

Timely Filing

These instructions apply to all contractors for claims filed in the timely filing period for managed care enrollees who have elected hospice. The timely filing period extends from the date of service to the end of the calendar year after the year service was rendered. However, if a service was provided in the fourth quarter of a calendar year, the claim will be timely to the end of the second year after the year in which the service was rendered. Since there have been allegations of lack of compliance with the regulatory requirements for Medicare fee-for-service contractors to process hospice claims for managed care beneficiaries, exceptions to timely filing will be considered on a case-by-case basis. Exceptions to the timely filing requirements will be determined by Medicare contractors on a case-by-case basis in accordance with applicable CMS guidelines.

Physician Billing Instructions For Non-Hospice Services

CMS has specific coverage rules that apply when an individual is covered under a Medicare hospice program. Treatment for the specific hospice related condition is covered under the scope of the hospice benefit. Treatment for non-hospice related services must be specifically billed to denote the following:

1. Services are not related to the specific terminal illness covered through hospice. For example, the hospice related illness is congestive heart failure.
2. A separate medical condition not related to treatment for hospice is eligible for payment under Medicare Part B, provided the billing is done properly (the specific codes designated by Medicare (i.e., GW modifiers) are utilized when billing). A separate medical condition not related to treatment for congestive heart failure is eligible for payment under Medicare Part B, provided the medical documentation regarding the separate medical condition is included.
3. Separate, non-hospice related treatment for things such as renal failure or related red blood cell production issues that meet Medicare criteria for Procrit injections would be distinct from the CHF condition being treated under the hospice program. As such they are eligible for coverage under Medicare Part B.
4. The billing should be done with a GW modifier and should denote that the treatment is not for the CHF condition, which is coded as covered under hospice.

Resources: Medicare Hospice Manual; discussion with the Hospice staff confirming that the Renal Failure and Red Blood cell production issues are not part of the scope of the hospice treatment for CHF; Frank Abrahamian at US Government Services; and conversations with CMS staff and NHIC staff; DHHS Program Memorandum.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Interim Billings

Interim bills for services subject to reimbursement at either a Case Rate or Per Diem Rate will be paid at the applicable Case Rate and/or Level of Care Per Diem Rate as they are received. When the final bill (type of bill 114) is received it will be paid at per diem with an EOB message that reads: "We have made a courtesy payment on this claim. Please resubmit the claim if it is determined to be a Stop Loss payment situation after the patient is discharged."

Once Blue Shield receives the resubmitted claim, complete with admit to discharge itemization, we will verify Stop Loss contract language, review previous payments, and adjudicate the claim accordingly. Additional information may be requested before final Stop Loss payment can be determined.

Intermediate Inpatient Accommodation Services

Intermediate Inpatient Accommodation Services are considered to be Medical/Surgical Level of Care accommodation services, unless otherwise noted in the provider contract or as determined by Utilization Review.

Newborn Screening Program

Department of Health Services (DHS) Genetic Disease Branch (GDB)

DHS's Genetic Disease Branch that administers the state's mandatory Newborn Screening Program advised newborn screening providers that they will not bill patients or health plans for these services. These services must be billed by the facility collecting the specimen. Blue Shield's payments for these services are included in the hospital's capitated or per diem rates.

Observation Services

Blue Shield reimburses observation services pursuant to the contract, which may differ from the payment methodology used by other payors, including Medicare. These services may be included in the global case reimbursement or included in the inpatient reimbursement if the member is subsequently admitted.

Pre-Operative Testing

Pre-operative testing is defined as tests performed prior to, and required for, the surgery generally including but not limited to all clinical laboratory services and diagnostic tests. The pre-operative testing period can cover any timeframe of one hour to one month before the actual surgery.

All pre-operative testing required for the surgery should be billed on the same claim as the applicable surgery in order to receive payment. All pre-operative tests performed are considered to be included in the surgical case rate.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Present on Admission (POA)

Specific details for billing the POA indicator are available on Provider Connection at [blueshieldca.com/provider](https://www.blueshieldca.com/provider) under the *Claims* tab.

The HIPAA 5010 837 contains specific details where the POA is located. Please refer to the HIPAA Implementation Guidelines or the FAQs for EDI, ERA & EFT located on Provider Connection at <https://www.blueshieldca.com/provider/claims/electronic-transactions/faq.sp>

Rehabilitation Therapy Inpatient (Medicare)

Inpatient rehabilitation therapy services are paid under Inpatient Rehabilitation Facility Prospective Payment System (IRFPPS).

Payments are based on the Case-Mix Group (CMG) supplied by the provider. Providers must supply the CMG Code billed with Revenue Code 0024 with zero billed amounts on the line.

Refer to the *Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing*.

Section 4: Billing and Payment

Special Billing Situations *(cont'd.)*

Self-Referral

Billing for services that are considered "self-referred" should be billed as:

For Professional Claims

Loop 2310F NM103= SELFREFERRAL

Loop 2310F NM104= BLANK

First Name = SELFREFERRAL

Last Name = BLANK

Sample: NM1*DN*1*SELFREFERRAL*****XX*1002233777~

For Institutional EDI Claims

Loop 2310F NM103= SELFREFERRAL

Loop 2310F NM104= BLANK

First Name = SELFREFERRAL

Last Name = BLANK

Sample: NM1*DN*1*SELFREFERRAL*****XX*1002233777~

Skilled Nursing (Medicare)

Skilled nursing inpatient services are paid under a Prospective Payment System (PPS). Providers who have language in their Agreement to pay at a percent of Provider's billed charges in accordance to the Charge Master; the reimbursement rates set forth in the Agreement; and the reimbursement established by the Medicare program to pay at the lesser of contracted rates or at Medicare reimbursement, will be subject to claims being priced at the PPS fee schedules regulated by CMS.

Providers **must** supply the appropriate CMS Skilled Nursing Facility Health Insurance Prospective Payment System ("SNF HIPPS") code and zero charges. This information is required in order to price the claim at the Medicare rates. If the SNF HIPPS(s) code is not on the claim, the claim shall default to the lowest SNF HIPPS(s) level for the provider's locality for determining reimbursement in accordance with the Provider's Agreement. Refer to the *Medicare Claims Processing Manual Chapter 6 – SNF Inpatient Part A Billing and SNF Consolidated Billing*.

Section 4: Billing and Payment

Where to Submit Claims

Commercial Exception Claims

Hospitals with negotiated exception rates should submit paper claims (manufacturer invoice, when applicable) along with the UB 04 and itemization to the following address:

Blue Shield of California
Hospital Exception Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010
(800) 258-3091

For BlueCard claims, hospitals with negotiated exception rates should submit paper claims (manufacturer invoice, when applicable) along with the UB 04 and itemization to the following address:

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

For more detailed information about the BlueCard Program claims process, refer to Appendix 5-A of this manual or access the BlueCard Program web page at blueshieldca.com/provider.

Section 4: Billing and Payment

Where To Submit Claims *(cont'd.)*

Electronic Claims

Claims are submitted in the ASC X12 837 5010 format. Blue Shield has contracted with several vendors for providers to submit claims at no cost.

To enroll in electronic claim submission, providers can use any approved clearinghouse listed on Provider Connection. Provider can submit claims at no charge using vendors Office Ally, TriZetto Provider Solutions or Ability Network. These vendors can be contacted at blueshieldca.com/provider in the *Claims* section under *How to submit claims* or by contacting the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

The many benefits to the provider for using electronic submission include reporting/acknowledgment of receipts, faster payment, improved accuracy, no claim forms, no postage and handling, and the ability to submit to a single location.

The creation of the National Provider Identifier (NPI) was mandated by the Health Insurance Portability and Accountability Act (HIPAA). The NPI is an attempt to ensure that all medical providers can be identified by a single identifier across all payor systems. To implement the NPI, Blue Shield developed a plan to cross reference the NPI to the correct provider records in our system. Providers must apply for their type 1 and/or type 2 National Provider Identifier through the CMS NPPES website. The NPI needs to be registered with Blue Shield before submitting claims.

HIPAA 5010 went into effect January 1, 2012. This federal regulation requires the use of standard X12 transactions to report and inquire about healthcare services. For questions about 5010, please contact the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

Section 4: Billing and Payment

Where To Submit Claims *(cont'd.)*

Paper Claims

For faster processing and turnaround, please submit all claims electronically. When medical records must be submitted, please use the post office box assigned by the member's plan type. Claims may also be sent to Blue Shield's central mail processing facility for appropriate distribution, although this process may cause some delay. Please refer to Appendix 4-C for a listing of these locations, as well as claims submissions locations for specific programs/accounts.

Transplant Claims*

The Transplant All-Inclusive Global Case Rate Payment Period includes all inpatient and outpatient hospital, professional, ancillary services, and products received by the patient during the Global Case Period.

Itemized institutional and professional bills must be submitted on appropriate billing forms, e.g., UB 04 (or successor) forms for institutional services or CMS 1500 claim forms for professional services and attached to the Blue Shield Organ Transplant Package Billing Form (Included in the Exhibit C of the Transplant Amendment signed by the facility) unless otherwise stated in your contract.

Hospitals that are submitting Package Billings for transplant or transplant related services should send paper claims along with the Organ Transplant Package Billing Form to the following address:

Blue Shield of California
Hospital Exception and Transplant Unit
P.O. Box 629010
El Dorado Hills, CA 95762-9010
(800) 258-3091

* This does not apply to kidney transplants unless the facility has an exception case rate specific to kidney transplants.

Section 4: Billing and Payment

BlueCard® Program Claims

The BlueCard® Program is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan's service area. The program links participating healthcare providers with all independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

The program allows hospitals and facilities to conveniently submit claims for patients from out-of-state Blue Plans, either domestic or international, to Blue Shield of California. Blue Shield is your primary contact for BlueCard claims processing, correspondence and provider inquiries.

For faster processing and turnaround, please submit all claims electronically. All claim correspondence and paper claim forms that require medical records, can be mailed to BlueCard Program:

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

For more detailed information about the BlueCard Program claims process, refer to Appendix 5-A of this manual or access the BlueCard Program web page at https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/qui_delines_resources/bluecard.

Section 4: Billing and Payment

Facility Compliance Review (FCR)

In order to comply with our employer group and provider contract agreements and to ensure that appropriate billing practices are followed, Blue Shield has developed a comprehensive Facility Compliance Review (FCR) program that involves a comprehensive line-by-line bill audit. The program reviews inpatient and outpatient claims to validate their conformance with provisions of the facility's agreement.

Blue Shield audits claims for billing accuracy, allowable charges, medical necessity, Hospital Acquired Conditions and Never Events to ensure consistency with currently accepted standards in the industry. These standards include but are not limited to those defined by Optum reference manuals and followed by other commercial payors, as well as the UB 04 Billing Manual guidelines and the National Uniform Billing Committee guidelines. The program encompasses Blue Shield claims for all lines of business and all facilities.

Categories of charges that are subject to review and payment denial include but are not limited to those charges that are mutually agreed to in Blue Shield's hospital contracts; those charges that are determined to be not medically necessary; those for which there is no substantiating documentation; and those considered to be unbundling of another global charge, such as room and board charges or other facility room charges. Precedence for denial of such charges has been established by Optum resource manuals, and other commercial payors, as well as the Uniform Bill (UB04) Billing Manual guidelines and definitions.

To complete an audit as expeditiously as possible, Blue Shield may ask a hospital to submit medical records; Emergency Room Notes, Trauma Flowsheet, Physician Progress Notes, Physician Orders, History and Physical, Consultations, Discharge Summary, Operative Report and Implant Log. Blue Shield may request a copy of the UB 04 (or successor) and a detailed itemization if the claim has been electronically submitted. Timely submission of requests will expedite claims processing.

For questions regarding this program, please contact Provider Information & Enrollment at (800) 258-3091.

Appeals to the Facility Compliance Review results must be submitted in writing and include specific detailed supporting documentation to the following address:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Section 4: Billing and Payment

Incidental Procedures

Incidental procedures are outpatient services provided to members in conjunction with other outpatient covered services. Incidental procedure services and supplies are considered included in a global procedure charge(s).

A list of incidental procedures is provided in Appendix 4-D of this manual.

Hospital-Acquired Conditions / Never Events

Blue Shield believes that when a member enters a hospital for treatment of a medical problem, the member should not suffer or experience additional injuries, infections, or other serious conditions during the course of the member's stay. Accordingly, Blue Shield expects all Blue Shield participating hospitals to take proper precautions to prevent unnecessary and avoidable injuries or illnesses. As part of Blue Shield's commitment to improving the quality of care available to members, Blue Shield has adopted payment policies that encourage hospitals to reduce the incidence of certain hospital-acquired conditions (HACs) and "Never Events."

HACs are avoidable conditions that could reasonably have been prevented through application of evidence-based guidelines. Such conditions are not present when patients are admitted to a hospital but occur during the course of the stay.

Never Events are errors or events that should never happen in a hospital. The Centers for Medicare & Medicaid Services (CMS) defines Never Events as "serious and costly errors in the provision of health care services that should never happen."

Blue Shield will not pay or otherwise reimburse participating hospitals for inpatient services related to those HACs and Never Events listed on Provider Connection at www.blueshieldca.com/bsca/bsc/wcm/myconnect/provider/provider_content_en/claims/policies_guidelines/payment_policies.

Section 4: Billing and Payment

Hospital-Acquired Conditions / Never Events *(cont'd.)*

Specifically:

- Blue Shield will not reimburse hospitals for services provided during an inpatient admission that would not have been provided in the absence of a HAC, including a higher level of care or additional inpatient days. Following are various reimbursement methodologies and how the presence of a HAC may modify reimbursement:
 - **Per Diem Rate Reimbursement** – If the HAC does not impact the member’s length of stay or the level of care provided to the member, no adjustment will be made to the per diem rate reimbursement otherwise payable to the hospital. If, as a consequence of the HAC, the member’s length of stay is increased, Blue Shield will not reimburse the hospital for any additional inpatient days attributable to the HAC. If, as a consequence of the HAC, the member receives services at a level of care higher than that which the member would have received in the absence of the HAC, Blue Shield will reimburse the hospital at the per diem rate applicable to the level of care that would have been necessary had the HAC not occurred.
 - **Case Rate Reimbursement** – If the HAC does not impact the member’s length of stay or the level of care provided to the member, no adjustment will be made to the case rate reimbursement otherwise payable to the hospital. If, as a consequence of the HAC, the member’s length of stay exceeds the number of days covered by the applicable case rate, Blue Shield will reimburse the hospital at the applicable case rate only. If the HAC does not impact the member’s length of stay, but, as a consequence of the HAC, the member receives services at a level of care higher than that which the member would have received in the absence of the HAC, Blue Shield will reimburse the hospital for any days exceeding the number of days covered by the applicable case rate at the per diem rate applicable to the level of care that would have been necessary had the HAC not occurred.

Section 4: Billing and Payment

Hospital-Acquired Conditions / Never Events *(cont'd.)*

- **Percent of Charge-Based Reimbursement** – Blue Shield will not pay or reimburse any charges for services related to the HAC. If, as a consequence of the HAC, the member receives services at a level of care higher than that which the member would have received in the absence of the HAC, Blue Shield will reimburse the hospital only for charges applicable to the level of care that would have been necessary had the HAC not occurred.
- **DRG Reimbursement** – Blue Shield will not pay or reimburse the hospital for any services related to the HAC. Reimbursement will be calculated as though the secondary diagnosis was not present.
- **Stop Loss Reimbursement** – For purposes of calculating stop loss reimbursement, if any, payable to the hospital, Blue Shield will disallow all charges for services related to the HAC.
- Blue Shield will not reimburse hospitals for any services related to a Never Event.
- In no event, including, without limitation, nonpayment by Blue Shield, shall a participating hospital bill, charge or seek compensation or reimbursement from a member, or any individual responsible for such member's care, for hospital services related to a HAC or Never Event. Without limiting the foregoing, participating hospitals shall not seek payment from a member, or any individual responsible for such member's care, for Covered Services for which payment was denied by Blue Shield because such Covered Services were related to a HAC or Never Event.

The list of Hospital Acquired Conditions (HAC)/Never Events identifying codes are listed on Provider Connection at blueshieldca.com/provider.

Section 4: Billing and Payment

Blue Shield Explanation of Payments (EOP)

Blue Shield pays participating hospitals directly for covered services provided to our members. Providers are required to receive claims payments electronically via Electronic Funds Transfer (EFT). Providers are required to receive Electronic Remittance Advice (ERA) showing how the claim was processed or view Explanation of Payment (EOP) using Provider Connection at blueshieldca.com/provider. An Explanation of Benefits (EOB) is also provided to members advising them of their financial responsibility, if any.

When a Blue Shield network hospital provides services, we base payment on allowed amounts according to negotiated per diems, case rates, or percentage discounts (unless the hospital is a capitated HMO facility). These negotiated rates are based on the contract in effect on the day the patient is admitted to the hospital. These amounts provide the basis of the patient's liability. The EOB message on the member's copy will vary slightly from what appears on the hospital's copy and will indicate Blue Shield's payment to the hospital.

Tools at Provider Connection at blueshieldca.com/provider allow registered billing providers to find claim and payment details and generate claims reports. Providers can download a copy of the printed EOP from Provider Connection. The information displayed on the claims details section of the website is the same information found on the provider's printed EOP.

Electronic Remittance Advice (ERA)

Utilizing Electronic Remittance Advice (ERA) allows providers to reconcile their accounts receivable in a timely manner.

ERA data is used for automatic posting of claim payments. Auto-posting of payments requires assistance from your practice management system vendor.

ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. Providers are required to receive ERA files or view Explanation of Payment (EOP) using the Blue Shield's Provider Connection site at blueshieldca.com/provider. The ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format. The ERA replaces the paper Explanation of Payment. To enroll for the ERA, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the *Claims* section under *Enroll in EDI* or by contacting the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

Once ERAs are set up, paper EOPs will be discontinued. However, you can always retrieve copies of EOPs from Provider Connection at blueshieldca.com/provider.

To enroll in the ERA/EFT program, please complete the enrollment forms found on Provider Connection. Input ERA Enrollment form in the search tool bar and hit the link for enrollment forms. Fax completed forms to (866) 276-8456.

For questions regarding the ERA/EFT enrollment process, please call the EDI Help Desk at (800) 480-1221.

Note: When enrolling in the ERA/EFT program, you must register your National Provider Identifier (NPI) with Blue Shield of California.

Section 4: Billing and Payment

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Calculating Member Liability

Blue Shield is in compliance with California Senate Bill 1085 (also known as the Mello Bill), which requires that the member copayment be based on the negotiated (allowed) or billed amount, whichever is less.

The following is an example of how payment is calculated for an inpatient claim. For questions or clarification about the payment or the EOB, call the member's service center number that appears on the EOB.

Step 1: Calculate the Negotiated amount

\$755.00	Per Diem
x <u>6</u>	Days
\$4530.00	

Step 2: Calculate member liability (deductible, coinsurance, copayment, and sanction) based on the billed charges or negotiated amount, whichever is less.

\$5255.95	Billed Charges
<u>\$4530.00</u>	Negotiated Amount

Because the negotiated amount is less than the total billed charges, the member liability is calculated using the negotiated amount

	\$4530.00	Negotiated Amount
Deductible	<u>- \$100.00</u>	Deductible Amount
	\$4430.00	
Copayment	x 20%	
	\$886.00	Copayment Amount

Total Member Liability is calculated as the sum of the deductible, coinsurance, copayment, and sanction

	\$100.00	Deductible Amount
	<u>+ \$886.00</u>	Copayment Amount
Total Member Liability:	\$986.00	

Section 4: Billing and Payment

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Calculating Member Liability *(cont'd.)*

Payment Totals:	\$3544.00	Blue Shield payment
	<u>+ 986.00</u>	Member liability
	\$4530.00	Total payment to facility

See Appendix 4-A for examples of payment calculations for outpatient services.

Contractual Adjustment Amount

EOBs report the contractual adjustment dollars to any participating provider. Contractual adjustment is the difference between the total billed charges and Blue Shield's allowed amount or contracted rate amount or usual and customary fee (a write-off amount). Having the contractual adjustment on the EOB will give an accurate amount for the provider's accounts receivable department. Also, along with the contractual adjustment amount, the EOB will have a message explaining what the amount is.

The new messages are as follows:

1. (Adjusted claim) - Your contractual adjustment is <insert #>
2. Your contractual adjustment is <insert #>

See examples for computing contractual adjustment:

Example 1: Negotiated Rate Facility

Claim billed amount: \$1500.00
Contracted Allowed Amount: \$1250.00
Total Contractual Adjustment: \$250.00
Total Blue Shield (paid) amount: \$1125.00

\$1500.00	Facility's billed amount
<u>- \$1250.00</u>	Contracted allowed amount
\$250.00	Contractual adjustment amount

\$1250.00	Allowed amount
<u>- \$125.00</u>	Coinsurance
\$1125.00	Blue Shield payment

Section 4: Billing and Payment

Blue Shield Explanation of Payments (EOP) *(cont'd.)*

Contractual Adjustment Amount *(cont'd.)*

Example 2: Negotiated Rate Facility

Claim billed amount: \$4000.00
Contracted Allowed Amount: 20% discount
Total Contractual Adjustment: \$800.00
Total Blue Shield (paid) amount: \$2880.00

\$4000.00	Facility's billed amount
<u>- \$3200.00</u>	Contracted allowed amount
\$800.00	Contractual adjustment amount
\$3200.00	Allowed amount
<u>- \$320.00</u>	Coinsurance
\$2880.00	Blue Shield payment

Check Issuance

Please notify Blue Shield immediately, in writing to the address below, if the remittance address of your hospital changes.

Blue Shield of California
Provider Information & Enrollment
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Be sure to include your Blue Shield provider number on all billings and correspondence with us. Payments can be received electronically through Electronic Funds Transfer (EFT). Contact the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com for more information.

Calculating Allowed Amounts

In calculating allowed amounts, Blue Shield may round the figure to the nearest whole dollar.

Section 4: Billing and Payment

Third Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a “third party”), Blue Shield and the hospital or facility will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from the third party, third party insurer or from uninsured or underinsured motorist coverage, Blue Shield and the hospital or facility have the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

3. Notify Blue Shield and the hospital or facility in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party;
4. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;
5. Agree, in writing, to reimburse Blue Shield for benefits paid from any recovery received from the third party;
6. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party’s agent or attorney, or the court, unless otherwise prohibited by law; and,
7. Respond to information requests regarding the claim against the third party and notify Blue Shield and the hospital or facility in writing within ten (10) days of any recovery obtained.

If this plan is part of an employee welfare benefit plan subject to the Employee Retirement Income Security Act (ERISA), the member is also required to do the following:

1. Ensure that any monetary recovery is kept separate from the member’s other assets and agree in writing that the amount necessary to satisfy the lien is held in trust for Blue Shield; and,
2. Instruct legal counsel retained by the member to hold the portion of the recovery to which Blue Shield is entitled in trust for Blue Shield.

Section 4: Billing and Payment

Coordination of Benefits (COB)

Coordination of Benefits (COB) is utilized when a member is covered by more than one group health plan. Payments for “allowable expenses” will be coordinated between the plans up to the maximum benefit value or amount payable by each plan separately.

COB ensures that benefits paid by multiple group health plans do not exceed 100% of eligible expenses and the plans follow a consistent order of payment.

Determining the Order of Payment

When a plan does not have a COB provision, that plan will provide its benefits first. Otherwise, the plan covering the person as an employee will provide its benefits before the plan covering the person as a dependent.

The following applies to coverage for dependent children:

- When the parents are not divorced or separated, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary. If either parent’s plan does not have a COB provision regarding dependents, this rule does not apply. The rule established by the plan without a COB provision determines the order of benefits.
- When the parents are divorced or separated and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, that parent’s group health plan is primary. The group health plan of the other parent is secondary.
- When the parents are not married, or are divorced or separated and there is no court order which would otherwise establish coverage for the child, primary responsibility is determined in the following order:
 1. The group health plan of the custodial parent.
 2. The group health plan of the spouse of the custodial parent.
 3. The group health plan of the non-custodial parent.
- When the parents are divorced or separated and there is a court decree that the parents share joint custody, without specifying which parent is responsible for the health care expenses of the child, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

If the above rules do not apply, the plan that has covered the person for the longer period of time is the primary plan provided that:

- The group health plan covering the person, or the dependent of such person, as an active employee provides benefits before the group health plan that covers the person, or the dependent of such person, as a laid-off or retired employee. If either plan does not have a COB provision regarding laid-off or retired employees, this rule does not apply.

Section 4: Billing and Payment

Coordination of Benefits *(cont'd.)*

When Blue Shield is the Primary Plan

The hospital or facility will provide Blue Shield Plan benefits without considering the existence of any other group health plan.

Upon request, the hospital or facility will provide the member or the secondary group health plan with a statement documenting copayments paid by the member or services denied so the member may collect the reasonable cash value of those services from the secondary group health plan. It is not necessary to provide the member with an itemized billing.

When Blue Shield is the Secondary Plan

If, as the secondary plan, the hospital or facility covers a service that would otherwise be the primary group health plan's liability, the hospital or facility may collect the reasonable cash value of that service from the primary group health plan.

When a disagreement exists as to which group health plan is secondary, or the primary group health plan has not paid within a reasonable period of time, Blue Shield will provide benefits as if it were the primary group health plan, provided the member:

- Assigns to Blue Shield the right to receive benefits from the other group health plan;
- Agrees to cooperate with Blue Shield in obtaining payment from the other group health plan; and
- Allows Blue Shield to verify benefits have not been provided by the other group health plan.

References

Additional information regarding COB is available through the following references:

- California Code of Regulations, Title 28, Section 1300.67.13
- The member's *Evidence of Coverage*

Section 4: Billing and Payment

Limitations for Duplicate Coverage (Commercial)

Veterans Administration (VA)

The member's primary plan is required to pay the Veterans Administration (VA) for medically necessary plan benefits provided to the member who is a qualified veteran at a VA facility for a condition unrelated to military service (based on the reasonable value or Blue Shield's allowable amount). The VA claims cannot be denied solely because the member failed to obtain a referral or authorization.

If an issue arises as to whether an illness or injury is related to military service, the VA determination prevails. While the VA determination is not subject to review, the VA will, upon request, provide documentation to substantiate its decision.

If the member is treated by the VA, the VA notifies Blue Shield by sending a copy of an assignment of benefits and will cooperate with requests for medical records. The VA will accept payment equal to what would ordinarily be paid to other providers in its geographic area. Regular administrative procedures should be followed, as if the VA were part of the member's IPA/medical group.

Department of Defense (DOD) – TRICARE/CHAMPVA

Blue Shield is always primary (unless another group plan is primary) for covered services provided at a Department of Defense (DOD) facility when the member is not on active duty, even if for a condition related to military service. Payment is based on the reasonable value or Blue Shield's allowable amount. TRICARE - CHAMPVA will not provide payment if the services are a benefit through Blue Shield but were not paid because the member did not comply with service delivery rules (e.g., non-authorized out of network non-emergency/urgent services). TRICARE - CHAMPVA may cover other services excluded by Blue Shield.

Section 4: Billing and Payment

Limitations for Duplicate Coverage (Commercial) *(cont'd.)*

Medi-Cal

Medi-Cal is considered a payor of last resort.

Medicare Eligible Members

1. Blue Shield will provide benefits **before** Medicare in the following situations:
 - a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payor laws).
 - b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payor laws).
 - c. When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
2. Blue Shield will provide benefits **after** Medicare in the following situations:
 - a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payor laws).
 - b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payor laws).
 - c. When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
 - d. When the Member is retired and age 65 years or older.

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.

Section 4: Billing and Payment

Limitations for Duplicate Coverage (Commercial) *(cont'd.)*

Services for Members in Custody of the Penal System

Section 1374.11 of the Health & Safety code prohibits health care plans from denying hospital, medical, or surgical services for the sole reason that the individual served is confined in a city or county jail, or is a juvenile detained in any facility if the individual is otherwise entitled to receive services. Blue Shield health plans are also required to provide covered services when the member is injured during the act of committing a crime.

Transition of Care / Financial Responsibility Upon Enrollment/Disenrollment for Medicare Advantage Members

The following language is taken from the Code of Federal Regulations §422.322 Source of payment and effect of election of the MA plan election on payment, Federal Regulation §422.318, and Federal Register Part 412 - Prospective Payment Systems for Inpatient Hospital Services.

Transfers/Discharges

If a transfer from one inpatient area or unit within a facility to another unit within the same facility occurs during a member's hospitalization, this is a continuous admission and the source of coverage and financial responsibility typically remains unchanged. (Does not apply for transfers to acute rehab, TCU, or SNF level of care.)

If a member is discharged from one facility and admitted to another during his/her hospitalization, the financial responsibility depends on the source of coverage at the time of the second admission.

A discharge indicates that one of the following has occurred:

- The member moves from a PPS level of care to a non-PPS level of care, such as to an acute rehab, TCU or SNF facility.
- The member is transferred to another PPS facility, typically representing a change in the level of care.
- The member is discharged from the acute inpatient facility.

Section 4: Billing and Payment

Transition of Care / Financial Responsibility Upon Enrollment/Disenrollment for Medicare Advantage Members *(cont'd.)*

Prospective Payment System (PPS) Participating Hospitals, Skilled Nursing Facilities (SNF), Home Health Agency (HHA), etc.

Members hospitalized prior to their Effective Date with the Blue Shield Medicare Advantage plan.

- If a member is an inpatient in an acute hospital facility prior to his or her effective date with the Blue Shield Medicare Advantage plan, the member's *current* source of coverage at the time of admission is financially responsible for all medically necessary Medicare Part A (hospital) services through the date of discharge or through the date of transfer to an alternate facility. Blue Shield is not required to provide nor assume responsibility to pay for any inpatient services covered under Medicare Part A during the inpatient stay. Part B or physician services become a responsibility of the IPA/PCP/delegated group as of the member's effective date.
- Under the above circumstances Blue Shield Plan Providers will assume responsibility for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. Discharge to a skilled nursing facility is considered as an inpatient hospital discharge.

Caution: Under the above rules, CMS has viewed a "transfer to an in-plan hospital" as a discharge in the past. This makes the Health Plan liable for the admission from the date of the transfer and Medicare pays the "transfer payment" to the facility to which the member was an inpatient at the time of admission.

Prospective Payment System (PPS) Participating Hospitals

Coverage Terminates While the Blue Shield Medicare Advantage Plan Member is Hospitalized.

If Blue Shield coverage terminates while the member is hospitalized, regardless of the reason for the termination, and the admission was authorized by the member's IPA/PCP, Blue Shield liability for inpatient hospital services will continue until the member is discharged. Responsibility for Part B/physician services ends on the member's disenrollment effective date.

Section 4: Billing and Payment

Transition of Care / Financial Responsibility Upon Enrollment/Disenrollment for Medicare Advantage Members *(cont'd.)*

Non-Prospective Payment System (PPS) Hospitals

Although most hospitals are part of the Medicare Prospective Payment System, there are limited facilities, such as Children's hospitals that are excluded from PPS reimbursement. Should that be the case, the above rules do not apply if the hospital is not a PPS hospital. In cases where the member is in a non-PPS hospital the member's new source of coverage is financially responsible for all medically necessary services as of the enrollment/disenrollment date.

Skilled Nursing Facility

If a member is in a skilled nursing facility on the effective date of his/her enrollment/disenrollment, the member's new source of coverage is financially responsible for all medically necessary services as of the enrollment/disenrollment date.

Claim Inquires and Adjustments

Claim Inquiries

Blue Shield is committed to making payment within 30 days of receipt of a properly completed claim form. To check the status of an unpaid claim, refer to the following sections.

You can check the status of claims by accessing Provider Connection at blueshieldca.com/provider or, you can check the status of a claim by transmitting a 276 electronic claim status transaction. Initial enrollment and testing are required for submitting electronic transactions. Please contact the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

Section 4: Billing and Payment

Claim Inquiries and Adjustments *(cont'd.)*

Electronic Claim Submission

Blue Shield acknowledges receipt of a claim within two calendar days of the receipt of the claim. If you do not receive payment or notification after 10 days from the original claim submission, you can:

- Check the status of claims by accessing Provider Connection;
- Transmit an EDI 276 electronic claim status transaction; (for more information on transmitting EDI 276 transactions please contact the EDI Help Desk at EDI_BSC@blueshieldca.com or (800) 480-1221); or
- Call the member's assigned service center (shown on the member's ID card). For claims with dates of service less than 30 days old, Customer Service will refer the provider to Provider Connection where this information is readily accessible.

If Blue Shield cannot locate the claim, check your Blue Shield of California EDI Acknowledgement Reports (i.e., TA1, 999, 277CA) or your clearinghouse/billing service proprietary reports subsequent to the date you transmitted your claim to determine if the claim was rejected prior to entering Blue Shield's processing system.

- Create another claim (include any late charges with this copy of the claim) and resubmit claim electronically.
- Blue Shield will process your tracer for payment if we check our files and are unable to find any record of your original billing.
- Please contact our EDI Help Desk at EDI_BSC@blueshieldca.com or (800) 480-1221 or email bsc_edi@blueshieldca.com first before resubmitting a claim if not found rejected on reports.

Section 4: Billing and Payment

Claim Inquiries and Adjustments *(cont'd.)*

Paper Submission (When Medical Records are Required)

Providers can, within 15 calendar days of Blue Shield's receipt of the claim, verify receipt of a claim by contacting Customer Services. If you do not receive payment or notification within 30 days from the original claim submission, you can:

- Check the status of claims by accessing Provider Connection
- Transmit an EDI 276 electronic claim status transaction; or
- Call the member's assigned service center (shown on the member's ID card).

If Blue Shield cannot locate the claim, providers may wish to submit a tracer. Please allow a minimum of 30 days from the original submission date before sending a tracer as the *Explanation of Benefits* (EOB) and the inquiry may simply have crossed in the mail. To initiate a tracer, providers must:

- Prepare a legible copy of the original claim and check it for clerical errors or omissions, which may have delayed payment. Add any late charges to this copy of the claim and include detailed supporting information.
- Mail the tracers in an envelope, separate from your regular claims, to the member's assigned service center or the appropriate regional service center.

Providers may use their own tracer form if it contains the following information:

- | | | |
|------------------------|---------------------|----------------------------|
| • Facility name | • Member ID number | • Date Blue Shield was |
| • Blue Shield provider | • Date of admission | • Dates of service on your |
| • Member name | • Patient name | • Total dollars billed |

It is always best to attach a legible copy of the original billing in case Blue Shield cannot find a record of the original claim.

Section 4: Billing and Payment

Claim Inquiries and Adjustments *(cont'd.)*

Paper Submission (When Medical Records Required) *(cont'd.)*

Late Charges

Electronic Submission

Submit late charges and adjustment/corrected claims electronically.

- Wait until the original claim is finalized.
- Create a new line with the date the late charges were incurred by entering the value of "5" in the third digit of the Type of Bill field (Form Locator 4). This identifies the claim as late charges only.
- Resubmit the claim electronically.

Once the initial claim has finalized in our system, resubmit the Late Charges claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on the adjusted claim:

- Send "5" in CLM*05-3 (Loop 2300) to indicate Late Charges of Prior Claim
Sample: CLM*12345656*500***11:A:5*Y*A*Y*I~
- Send "F8" in REF01 (Loop 2300)
- Send the 12-digit claim number from the incorrect original claim in REF02 (Loop 2300).
Sample: REF*F8*12345678912345~

Note: 12345678912345 should be replaced with the original claim number. Obtain the Blue Shield claim number via the claim status option on Provider Connection, from the explanation of benefits (EOB), or from the electronic remittance advice (ERA).

Paper Submission (When Required)

- Wait until the original claim is finalized.
- Print a legible copy of the late charges indicating type of bill xx5 for late charges.
- Submit the claim(s) to the appropriate address.
- Ensure the request is within the timely filing period as specified in the contract.

Section 4: Billing and Payment

Claim Inquiries and Adjustments *(cont'd.)*

Resubmissions or Corrected Claims/Adjustments

Resubmission

If a claim needs to be resubmitted because you have not received notice of adjudication, use the following steps:

- Confirm that the claim has not been received by accessing Provider Connection at blueshieldca.com/provider
- Transmit a 276 electronic claim status transaction
- If the original claim was not received, resubmit the claim electronically.

Corrected Claims

Submit corrected claims electronically to Blue Shield. Please wait for the original claim to finalize before sending a corrected claim to avoid denial as a duplicate.

Once the initial claim has finalized in our system, resubmit the corrected claim with the appropriate adjustment bill type. Corrected claims should be submitted within 365 days from the claim finalized date unless otherwise specified in the contract. You will also need to include the following EDI segments on the adjusted claim:

- Send "7" in CLM*05-3 (Loop 2300) to indicate Replacement of Prior Claim
Sample: CLM*12345656*500***11:A:7*Y*A*Y*I~
- Send "F8" in REF01 (Loop 2300)
- Send the 12-digit Blue Shield Payer Claim Control Number from the incorrect original claim in REF02 (Loop 2300).
Sample: REF*F8*12345678912345~

Note: 12345678912345 should be replaced with the original claim number. Obtain the Blue Shield claim number via the claim status option on Provider Connection, from the explanation of benefits (EOB), or from the electronic remittance advice (ERA).

Ensure the request is within the timely filing period as specified in the contract.

Note: Submit corrected claims originally processed by a Foundation for Medical Care directly to that Foundation.

Section 4: Billing and Payment

Claim Inquiries and Adjustments *(cont'd.)*

Resubmissions or Corrected Claims/Adjustments *(cont'd.)*

Important Information

Corrected claims submitted with no documentation clearly describing the correction being made may be processed as a raw claim or returned with a request for additional information regarding the change(s).

Timely Submission of Claims and Appeals

Claims appeals by providers must be in writing and must specify the basis for the appeal. Particular payment or procedural issues that are in question must be cited. Unless otherwise specified in your contract, the following time frames for submission of claims and appeals will apply:

- **New claims:** Within 180 calendar days, or the time specified in your contract, whichever is greater, from the last date of service or discharge date.
- **Claims requiring coordination of benefits with another carrier:** Within 120 calendar days of the primary carrier's payment determination
- **Initial Appeals:** Within 365 calendar days of the last Blue Shield payment or decision, or the time specified in your contract, whichever is greater
- **Final Appeals:** Within 65 working days of Blue Shield's initial determination or the time specified in your contract, whichever is greater.

Note: Blue Shield will deny any claims or appeals that are not submitted within these time frames.

Section 4: Billing and Payment

Provider Inquiries

A provider inquiry is a telephonic or written request to explain the rationale for a decision to reduce, delay, or deny services or benefits. An inquiry may also include questions or clarifications regarding proposed services or treatments, administrative procedures or claims payment. Issues or questions may be resolved at the inquiry level. An inquiry may or may not alter the original decision.

Providers may initiate inquiries regarding a decision by Blue Shield, including but not limited to a claims processing determination.

Inquires may focus upon areas such as:

- Payment Methodology
- Multiple Surgeries
- Corrected Billings
- Medical Policy
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Utilization Denials

Inquiries can be generated by either a telephone call or written correspondence to the member's appropriate Customer Service Department. For claims with dates of service less than 30 days old, visit Provider Connection at blueshieldca.com/provider where this information is readily accessible. Information about the Provider Appeals and Dispute Resolution Process and where to direct an inquiry can be found in this manual or by contacting the member's Customer Service Department.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution

Blue Shield has established fair, fast and cost-effective procedures to process and resolve provider appeals. Blue Shield's Provider Appeals and Dispute Resolution Process is accessible to both contracting and non-contracting providers.

Definitions

Appeal

A written notice to Blue Shield, submitted to the designated provider appeal address or digital online portal, challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted (paid at less than billed charges), or contested, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes or allowances, requests for reimbursement of an overpayment of a claim; administrative policies and procedures, administrative terminations, retro-active contracting, or any other contract issue.

Bundled Appeal

A written notice to Blue Shield, submitted to the designated provider appeal address or digital online portal, identifying a group of substantially similar multiple claims challenging, appealing, or requesting reconsideration of claims that have been previously denied, adjusted (paid at less than billed charges), or contested, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes allowances, or requests for reimbursement of an overpayment of a claim; that are individually numbered using the Blue Shield assigned claim number to identify each claim contained in the bundled appeal; or a group of substantially similar contractual appeals that are individually numbered using the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet. (For example, Section I A #1, Section I A #2, etc.)

Provider Inquiry

A telephone or written request for information, or question regarding claim status, submission of corrected claims, member eligibility, payment methodology rules (bundling/unbundling logic, multiple surgery rules), Medical Policy, coordination of benefits, or third party liability/workers compensation issues submitted by a provider to Blue Shield, or a telephone discussion or written statement questioning with the way Blue Shield processed a claim (i.e., wrong units of service, wrong date of service, clarification of payment calculation).

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Definitions *(cont'd.)*

Receipt Date

The working day when the provider appeal is first delivered to the designated Provider Appeal Office, post office box, or portal by physical or electronic means.

Appeal Determination Date

The working day when the written provider dispute determination or amended provider dispute determination is delivered by physical or electronic means.

Date of Contest, Denial, Notice, or Payment

The date Blue Shield's claim decision, or payment, is electronically transmitted (835) or deposited in the U.S. mail (*Explanation of Benefits*).

Unjust or Unfair Payment Pattern

Any practice, policy, or procedure that results in repeated delays in the processing and/or correct reimbursement of claims as defined by applicable regulations.

Unfair Billing Pattern

Engaging in a demonstrable and unjust pattern of bundling/unbundling or up-coding of claims, and/or other demonstrable and unjustified billing patterns.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Definitions *(cont'd.)*

Good Cause for Untimely Submission of Claims

Circumstances reasonably beyond the control of the provider that prevented the timely submission of a claim would be considered "good cause."

Examples of circumstances beyond the control of the provider, include, but are not limited to:

- Patient gave incorrect health coverage/insurance information (copy of an incorrect ID card);
- Patient was unable to provide health coverage/insurance information (patient was comatose, the patient expired before the information could be obtained, etc.);
- Natural disaster/acts of nature (fire, flood, earthquake, etc.);
- Acts of war/terrorism;
- System wide loss of computer data (system crash);
- BlueCard claims sent to the wrong Blue Plan.

Examples of Circumstances That Do Not Constitute "good cause":

- Claim was sent to the wrong carrier (Blue Cross instead of Blue Shield), but the provider had the correct health coverage/insurance information for Blue Shield of California membership.
- The claim was submitted timely, but Blue Shield was unable to process because the claim was not a complete claim (did not contain the minimum data elements to enter the claim into the system, i.e., missing a subscriber number).

Providers have an obligation to be responsible for appropriate timely billing practices.

Provider requests to review a claim timely filing denial because the provider believes there was good cause for the delay, will be handled as a provider appeal.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns

Reporting Unfair Billing Patterns

Blue Shield may report *providers* Blue Shield believes are engaging in unjust billing patterns to the DMHC.

Toll-free provider line **(877) 525-1295**

E-mail: **plans-providers@dmhc.ca.gov**

Providers may report instances in which the provider believes a *plan* is engaging in an unfair payment pattern to the DMHC's Office of Plan and Provider Relations.

Toll-free provider line **(877) 525-1295**

E-mail: **plans-providers@dmhc.ca.gov**

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Unfair Payment Patterns

Unjust payment patterns include:

- Imposing a claim filing deadline on three or more claims over the course of any three-month period, or less than 90 days for contracting providers; 180 days for non-contracting provider; 90 days from the primary payor's determination, when paying as a secondary/tertiary payor
- Failing to forward at least 95% of misdirected, capitated claims to the appropriate capitated entity within 10 working days of receipt, over the course of any three-month period
- Failing to accept at least 95% of late claim submissions, over the course of any three-month period, when the provider submits proof of Good Cause
- Failing to notify providers at least 95% of the time, in writing and within 365 days of the payment date, of intent to recover an overpayment, over the course of any three-month period
- Failing to notify providers, at least 95% of the time over the course of any three-month period, of the claim, name of the patient, date of service and a clear explanation of the basis upon which an overpayment was made.
- Failing to allow providers 30 working days, at least 95% of the time over the course of any three-month period, of their right to appeal a request to recover an overpayment
- Failing to acknowledge at least 95% of claims within 2 working days for electronic submissions, or 15 working days for paper submissions
- Failing to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim at least 95% of the time over any three-month period
- Including provider contract provision inconsistent with any of the applicable regulations of the Health and Safety Code or CCR, title 28 on three (3) or more occasions over the course of any three-month period
- Requesting medical records on more than 3% of claims, excluding professional emergency services and care claims, over the course of any 12-month period

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Unfair Payment Patterns *(cont'd.)*

- Requesting medical records on professional emergency services and care claims on more than 20% of the claims, over the course of any 12-month period
- Failing to process PPO and POS II, III claims within 30 working days or HMO and POS I claims within 45 working days at least 95% of the time over the course of any three-month period
- Failing to automatically pay interest penalties when processing exceeds the specified time frames at least 95% of the time over the course of any three-month period
- Failing to notify providers of the appeal process when a claim is denied, adjusted or contested at least 95% of the time over the course of any three-month period
- Failing to acknowledge initial provider appeals within 15 working days of receipt at least 95% of the time over the course of any three-month time period
- Failing to resolve and provide written determination of initial provider appeals within 45 working days of receipt
- Rescinding or modifying an authorization for health care services after the provider has rendered the service on three or more occasions over the course of any three-month period

Provider Contracts

Blue Shield informs contracting providers and capitated entities, initially upon contracting, or upon change of the Provider Appeal Resolution Process, of the procedures for submitting a provider appeal, including:

- Identity of the office responsible for receiving and resolving provider appeals
- Mailing address
- Telephone number
- Directions for filing an appeal
- Directions for filing bundled appeal
- The timeframe in which Blue Shield will acknowledge receipt of the appeal. The disclosures are made in contracts, in the various provider manuals and on Provider Connection at blueshieldca.com/provider.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Explanation of Benefits

An *Explanation of Benefits* (EOB) informs providers of the availability of Blue Shield's Provider Appeal Resolution Process and provide instructions for filing a provider appeal. An EOB is sent each time Blue Shield processes a provider submitted claim unless a provider is enrolled with Electronic Remittance Advice (ERA). Providers can retrieve a copy of the EOB from Provider Connection at blueshieldca.com/provider. The provider appeal resolution information is printed on page two of the provider's EOB. EOBs are issued to both contracted and non-contracted providers.

Online Access

The Provider Appeal Resolution Process is available to registered users on Provider Connection at blueshieldca.com/provider.

Provider Manuals

The Provider Appeal Resolution Process is documented in the *Hospital and Facility Guidelines*, *Independent Physician and Provider Manual*, and the *HMO IPA/Medical Group Procedures Manual*.

Blue Shield's Appeal Process

The following information outlines the process Blue Shield has established to allow providers and capitated entities to submit appeals.

Blue Shield's Provider Dispute and Resolution Department is responsible for the Provider Appeal Resolution Process.

Blue Shield's Senior Management is responsible for:

- The maintenance of the Provider Appeal Resolution Process;
- Review of the Provider Appeal Resolution operations;
- Noting any emerging patterns to improve administrative capacity, Blue Shield Provider Relations, claim payment procedures and patient care; and
- Preparing the required reports and disclosures.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Provider Appeals – Reports

Blue Shield will track each provider appeal and will report the following information in the Annual Plan Claims Payment and Dispute Resolution Mechanism Report:

- Information on the number and type of provider appeals received.
- A summary of the disposition of all provider appeals, including a description of the types, terms and resolution.

Internally, Blue Shield will review the provider appeal data to identify emerging patterns and trends and initiate the appropriate action.

Levels

Blue Shield's Provider Appeal Resolution Process consists of two levels: Initial and Final.

CCR, Title 28, Section 1300.71.38 requires health plans to offer an appeal process. State law does not require health plans to offer two levels.

Address For Submission of Written Initial Appeals

Written initial appeals must be submitted to the following address:

Blue Shield Initial Appeal Resolution Office
P.O. Box 272620
Chico, CA 95927-2620

Written initial appeals regarding commercial facility contract exception(s) must be submitted to the following address:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Please submit to the above addresses on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at blueshieldca.com/provider.

Required Information/Appeal

An appeal must contain the following information:

- The provider's name
- The provider's identification number and/or the provider's tax identification number
- Contact information – mailing address and phone number
- Blue Shield's claim number, when applicable
- The patient's name, when applicable
- The patient's Blue Shield subscriber number, when applicable
- The date of service, when applicable
- A clear explanation of issue the provider believes to be incorrect, including supporting medical records when applicable
- Proof of participation in the IPA's provider appeal process and when the original determination was made by the IPA (such as a copy of the IPA Appeal denial letter and/or denial letter EOB), when applicable

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Required Information/Appeal *(cont'd.)*

As applicable, bundled appeals must identify individually each item by using either the claim number or the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet.

Appeals Submitted With Incomplete Information

Appeals that are lacking the required information will be returned to the provider or capitated entity.

Blue Shield will return the appeal and notify the provider or capitated entity of the missing information necessary to categorize the submission as a provider appeal.

The original appeal, along with the additional information identified by Blue Shield, should be resubmitted to Blue Shield within 30 working days of the provider's receipt of the notice requesting the missing information.

Blue Shield will not require the provider to resubmit claim information or supporting documentation that has been previously received as part of the claims adjudication process.

Timeframe for Submitting Appeal

Initial appeals must be submitted within 365 days or the time specified in the provider's contract, whichever is greater, of Blue Shield's date of contest, denial, notice or payment.

In the event the appeal is regarding the lack of a decision, the appeal must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, after the time for contesting or denying a claim has expired.

Appeals alleging a demonstrable and unfair payment pattern by Blue Shield must be submitted within the timeframes indicated above, based on the date of the most recent action or inaction by Blue Shield.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Timely Filing of Appeals

If a contracted provider or capitated entity fails to submit an initial appeal or final appeal within the required timeframes, the provider or capitated entity:

- Waives the right for any remedies to pursue the matter further
- May not initiate a demand for arbitration or other legal action against Blue Shield
- May not pursue additional payment from the member.

In instances where the provider's contract specifies timeframes that are greater than the timeframes specified in Blue Shield's Provider Appeal Resolution process, the provider's contract takes precedence.

Blue Shield will review the untimely submission of a provider appeal when the provider's contract includes a good cause clause for the untimely submissions of provider appeals.

Timeframe for Providers to Contest Blue Shield's Request to Refund an Overpayment

Providers must submit notice contesting Blue Shield's refund request within 30 working days of the receipt of the notice of overpayment.

The provider's notice contesting Blue Shield's refund request must include the required information for submitting an appeal as well as a clear statement indicating why the provider believes that the claim was not over paid. A provider's notice that it is contesting Blue Shield's refund request will be identified as an appeal and handled in accordance with Blue Shield's Provider Appeal Resolution Process.

Timeframe for Acknowledgement of Appeals

Blue Shield will acknowledge the receipt of each appeal submission. Paper appeals are acknowledged within 15 working days and electronic submissions are acknowledged within 2 working days.

If the resolution of the appeal results in additional monies due to the provider, Blue Shield will issue payment, including interest when applicable, within 5 working days of the date of the written response notifying the provider of the appeal resolution.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Timeframe for Resolving Appeals

Blue Shield will resolve appeals within 45 working days of the receipt of the appeal.

In the event the original appeal was returned to the provider due to missing information, the amended appeal will be resolved within 45 working days of the receipt of the amended appeal.

If the resolution of the appeal results in additional monies due to the provider, Blue Shield will issue payment, including interest when applicable, within 5 working days of the date of the written response notifying the provider of the appeal resolution.

Resolution

Blue Shield will provide a written determination to each appeal, stating the pertinent facts and explaining the reason(s) for the determination.

The written determination of an initial appeal will notify providers and capitated entities of their right to file a final appeal.

Submitting Appeals on a Member's Behalf

Appeals submitted on a member's behalf will be treated as a member grievance and handled within the member grievance process.

Blue Shield will verify with the member that the provider has been authorized to submit an appeal (member grievance) on the member's behalf.

Section 4: Billing and Payment

Provider Appeals and Dispute Resolution *(cont'd.)*

Unfair Billing and Payment Patterns *(cont'd.)*

Final Appeals

Provider or capitated entities that disagree with Blue Shield's written determination may pursue the matter further by initiating a final appeal.

To initiate a written final appeal, providers and capitated entities must, within 65 working days of Blue Shield's initial determination, or the time specified in the provider's contract, whichever is greater, submit a request to the following address:

Blue Shield of California
Final Provider Appeal and Resolution Process
P.O. Box 629011
El Dorado Hills, CA 95762-9011

Written commercial appeals regarding facility contract exception(s) must be submitted to:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

Please submit to the above addresses on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at blueshieldca.com/provider.

The final appeal must be submitted in accordance with the required information for an appeal.

Blue Shield will, within 45 working days of receipt, review the final appeal and respond in writing, stating the pertinent facts and explaining the reason(s) for the determination.

Arbitration

If, after participating in the initial and final levels of the Provider Appeal Resolution Process, the provider or capitated entity continues to disagree with Blue Shield's payment or determination, the provider or capitated entity may submit the matter to binding arbitration as applicable and outlined in the provider's contract.

Section 4: Billing and Payment

Capitated Entity (IPA/Medical Group/Capitated Hospital) Appeal Resolution Requirements

IPA/Medical Group and Capitated Hospital Responsibilities

In accordance with state law, IPA/medical groups and capitated hospitals are required to establish a fair, fast, cost-effective provider dispute resolution process.

In the event an IPA/medical group or a capitated hospital fails to resolve provider disputes in a timely manner, consistent with state law, Blue Shield may assume responsibility for the administration of the IPA/medical group's or capitated hospital's dispute resolution mechanism.

Blue Shield Contracts

Blue Shield contracts require the IPA/medical group and capitated hospitals to establish and maintain a fair, fast, and cost-effective dispute resolution to process and resolve provider appeals.

The IPA/medical group and capitated hospital's dispute resolution process must be in accordance with Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36 1371.37 1371.38, 1371.4, and 1371.5 of the Health and Safety Code, and Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of the CCR, Title 28.

Section 4: Billing and Payment

Capitated Entity (IPA/Medical Group/Capitated Hospital) Appeal Resolution Requirements *(cont'd.)*

Quarterly Reports

IPAs, medical groups and capitated hospitals are required to create and retain for audit a tabulated report of each provider dispute received and/or reported. The report must be categorized by receipt date, and include the identification of the provider, type of appeal, disposition and outcome of the appeal and number of work days to resolve the appeal. A summary statistical report will be submitted quarterly in accordance with ICE-standardized formats.

Each individual appeal in a bundled appeal is reported separately.

Provider Appeal Documentation

Upon request, the IPA/medical group and capitated hospital will make available to Blue Shield, or the DMHC, all records, notes and documents regarding their provider dispute resolution mechanism and the resolution of provider appeals. Providing all supporting documentation at the time the initial dispute is submitted will help ensure timely processing.

Medical Necessity Denials

Blue Shield's Provider Appeal Resolution Process includes a process to allow any provider submitting a claim dispute to the IPA/medical group and/or capitated hospital's dispute resolution mechanism involving an issue of medical necessity or utilization review and unconditional right of appeal for that claim dispute.

Providers must submit their request to Blue Shield within 60 working days from the date they received the IPA/medical group and/or capitated hospital's determination.

Section 4: Billing and Payment

Provider Appeals of Medicare Advantage Claims

Providers have the right to file an appeal related to any initial claim decision by filing a request for redetermination. Medicare Advantage Appeals (for individual or group Medicare Advantage members) must be submitted to:

Blue Shield of California
Medicare Provider Appeals Department
P.O. Box 272640
Chico, CA 95927

Required Information/Appeal

An appeal must be submitted in writing and contain the following information:

- The provider's name
- The National Provider Identifier (NPI) and/or the provider's tax or social security number)
- Contact information – valid mailing address and phone number
- Blue Shield's Internal Control Number (ICN)/Claim number
- The patient's name
- The patient's Blue Shield subscriber number
- The date of service
- A clear explanation of issue the provider believes to be incorrect, including supporting medical records, when applicable
- Proof of participation in the IPA's provider appeal process and when the original determination was made by the IPA (such as a copy of the IPA Appeal denial letter and/or denial letter EOB).

Timeframe for Submitting Appeal

Initial appeals must be submitted within 365 calendar days, or the time specified in the provider's contract, whichever is greater, of Blue Shield's date of contest, denial, notice or payment.

If a contracted provider or capitated entity fails to submit an initial appeal within the required timeframes, the provider or capitated entity:

- Waives the right for any remedies to pursue the matter further
- May not initiate a demand for arbitration or other legal action against Blue Shield

Section 4: Billing and Payment

Provider Appeals of Medicare Advantage Claims *(cont'd.)*

Timeframe for Submitting Appeal *(cont'd.)*

- May not pursue additional payment from the member

In instances where the provider's contract specifies timeframes that are greater than the timeframes specified in Blue Shield's Provider Appeal Resolution process, the provider's contract takes precedence.

Blue Shield will review the untimely submission of a provider appeal when the provider's contract includes a good cause clause for the untimely submissions of provider appeals.

Resolution

Blue Shield will, within 60 calendar days of receipt of the provider request for redetermination, review the appeal and respond to the physician or provider using the Provider Appeal Resolution letter or the Remittance advice with either additional payment or an explanation for upholding the original claim determination.

The provider must have a process in place to handle all contracted provider requests for redetermination, resolving them in a timely manner, and in accordance with contractual agreements following CMS regulations.

Non-Contracted Providers

CMS requires Medicare Advantage Organizations (MAO) to apply the provider dispute resolution process for payment disputes between non-contracted and deemed providers. Non-contracted and deemed providers are defined as follows:

- A non-contracted provider is one that was not aware the patient was a private fee-for-service member at the time of service, e.g., an emergency situation.
- A deemed provider is one who was aware that the patient was a private fee-for-service member at the time of service, and therefore had the ability to view the plan's terms and conditions of payment.

Note: The provider dispute resolution process for payment disputes between non-contracted and deemed providers does not include Part D claims (Prescription Drug Plans).

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO) for a covered service is less than the amount that would have been paid under original Medicare. The disputes may also include instances where there is a disagreement between a non-contracted/deemed provider and the organization about the plan's decision to pay for a different service than that billed. An example would include down-coding.

A provider or supplier has the right to dispute a reimbursement decision made by an MAO Plan. A provider has the right to request a reconsideration of the denial of payment, within

Section 4: Billing and Payment

Provider Appeals of Medicare Advantage Claims *(cont'd.)*

Non-Contracted Providers *(cont'd.)*

60 calendar days for \$0 payments and 120 calendar days for underpayments after the receipt of notice of initial determination/decision. Providers who wish to submit an appeal must also submit a signed Waiver of Liability (WOL) statement holding the member harmless regardless of the outcome of the appeal. Providers should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement. If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is not submitted after 3 attempts and before the 60th calendar day, the plan may dismiss the provider appeal.

If the required information to process the dispute has not been submitted, Blue Shield will send a letter to the provider requesting the necessary documentation. If the additional documentation is not received within 60 calendar days from the date of request, Blue Shield will conduct a review based on what is available.

Blue Shield will resolve the appeal within 60 calendar days of the receipt of the dispute. In the event that the additional payment is warranted in favor of the provider and was due to an error by Blue Shield, interest will be included along with the additional payment.

After the MAO Plan makes its Payment Review Determination (PRD) decision, all Medicare non-contracted zero payment denials are auto forwarded to the Independent Review Entity (IRE). For non-contracted Medicare/CMC underpayments, providers can contact 1-800-Medicare. For cases that are dismissed, the provider has the right within 180 days to ask the plan to vacate (set aside) the dismissal action if the plan determines there is good cause to vacate. The provider also has the right to ask for an independent reviewer contracted with Medicare to review the decision to dismiss the appeal request within 60 calendar days to Maximus Federal Services, Inc.

To appeal the provider organization's decision upholding initial payment, the provider must submit a written request to:

Blue Shield of California
Medicare Provider Appeals Department
P.O. Box 272640
Chico, CA 95927

For additional information regarding the appeal process, and to review digital submission options that will be available to Medicare providers in December 2023, please visit Provider Connection at blueshieldca.com/provider.