SECTION 7: CLAIMS SUBMISSION

of the Professional Provider Office Manual

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This section provides information about claims submission. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

Section 7: CLAIMS SUBMISSION

FILING CLAIMS

As a participating provider, you agree to submit claims for Blue Cross and Blue Shield members on the CMS-1500 Health Insurance Claim Form. These forms may be submitted electronically through iLinkBlue or mailed hardcopy. All applicable information should be completed in full, including CPT codes, ICD-10-CM diagnosis codes and applicable medical records to support the use of modifiers or unlisted codes with a charge greater than $500 to ensure payment is made to you accurately and without delay.

Claims should include all services rendered during the visit, using a place of service designation, such as 11 for office. Our reimbursement allowable for the E&M service includes the components for physician work, practice expense and malpractice insurance. No additional room usage charge should be billed by any party, since the practice expense component includes overhead expenses, and is an integral part in the E&M or procedure allowable charge. This methodology applies to hospital owned and physician owned practices, and helps ensure that contractual benefits for our members are correctly applied to claims.

An example CMS-1500 claim form and instructions on completing are provided in Appendix II Forms of this manual.

CMS-1500 CLAIM FILING GUIDELINES

Blue Cross scans all paper claims to eliminate the need to manually enter the claims data into our system. Please follow the guidelines below to ensure that your claims are scanned properly, which will allow you to benefit from faster, more accurate claims processing:

- Blue Cross does not accept black and white hardcopy claim forms. Do not submit black and white copies, as data recognition can be affected and may delay the processing of claim payments. Black and white claims are less legible after they are scanned.
- Laser printed claims produce the best scanning results. If you use a dot-matrix printer, please use a standard 10 or 12 font ribbon when the type begins to fade.
- Use CMS-1500 claim forms that are printed on good quality paper. When the paper is too thin, the claim cannot be scanned properly.
- Type or computer print all information within the appropriate blocks on the CMS-1500 claim form. Information should not overlap from one block into another.
- Type or computer print Block 14. This information cannot be handwritten because only typed information can be scanned and converted to text file for our system to process.
- If there is a signature in Block 31, it should not overlap into Block 25 (Federal Tax ID number) because the Tax ID number cannot be read.

- Do not use any stamps or stickers on your claim forms. The scanning equipment has a lamp that distorts stamps with black ink and completely removes any information with red ink. Therefore, stamps with pertinent information in red ink, such as "Benefits Assigned" or "Corrected Copy," will be lost if the claim is scanned.

TIMELY FILING

Please Note: Not all member contracts/certificates follow the 15-month claims filing limit. Always verify the member's benefits, including timely filing standards, through iLinkBlue.

Blue Cross claims must be filed within 15 months, or length of time stated in the member's contract, of the date of service. Claims received after 15 months, or length of time stated in the member's contract, will be denied, and the member and Blue Cross should be held harmless for these amounts.

Blue Cross FEP Preferred Provider claims must be filed within 15 months from date of service. Members/ Non-preferred providers have no later than December 31 of the year following the year in which the services were provided.

Medicare claims must be filed within one calendar year after the date of service. Self-funded plans and plans from other states may have different timely filing guidelines. Please call Customer Care Center to determine what the claims filing limits are for your patients.

Blue Cross claims for OGB members must be filed within 12 months of the date of service. Claims received after 12 months will be denied for timely filing and the OGB member and Blue Cross should be held harmless. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim. OGB claims are not subject to late payment interest penalties.

NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard unique identifier for health care providers. CMS has assigned national provider identifiers (NPIs) to comply with this requirement. NPIs are issued by the National Plan and Provider Enumeration System (NPPES). This one unique number is to be used when filing claims with Blue Cross as well as with federal and state agencies, thus eliminating the need for you to use different identification numbers for each agency or health plan.

To comply with the legislation mentioned above, all covered entities must use their NPI and corresponding taxonomy code, where applicable, when filing claims. All providers who are being credentialed or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. Claims processing cannot be guaranteed unless you notify Blue Cross of your NPI(s) prior to filing claims using your NPI(s).

Notifying Blue Cross of Your NPI

Once you have been assigned an NPI, please notify us as soon as possible. To do so, you may use one of the following ways:

1. Include it on your Louisiana Standardized Credentialing Application (LSCA), Health Delivery Organization (HDO) Application or Blue Cross recredentialing application.
2. Include it on the online Provider Update Request Form located in the "Resources" section on the Provider page.

Filing Claims with NPIs

Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your Tax ID number (TIN). To appropriately indicate your NPI and TIN on UB-04 and CMS-1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified Blue Cross of your NPI, by using one of the methods above, prior to filing claims. See the first part of this section for more details on how to submit claims to Blue Cross.

For more information, including **who should apply** for an NPI and **how to obtain** your NPI, visit our website or CMS website. If you have any questions about the NPI relating to your Blue Cross participation, please contact Provider Credentialing & Data Management.

Ordering/Referring Physician

The ordering/referring provider's first name, last name and NPI are required on all applicable claims filed with Blue Cross. Claims received without the ordering/referring provider's information will be returned and the claim must be refiled with the requested information.

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 17B

Electronic 837P, Professional Claims:

- Referring Provider - Claim Level: 2310A loop, NM1 Segment
- Referring Provider - Line Level: 2420F loop, NM1 Segment
- Ordering Provider - Line Level: 2420E loop, NM1 Segment

MEDICAL CODE EDITING TOOL ON ILINKBLUE

On iLinkBlue you can find the claims-editing software (CES) system tool under the "Claims" menu option. This is a code-auditing reference tool designed to help providers calculate claim edit outcomes for both professional and outpatient facility claims. View our *iLinkBlue User Guide* for more information on researching code combinations in the CES system tool. It is available on our Provider page at www.bcbsla.com/providers >Resources >Manuals.

Please Note: The CES tool in iLinkBlue is not a pricing or claims processing tool. It is a research tool designed to evaluate code combinations in the Blue Cross claims-editing system.

ELECTRONIC PAYMENT REGISTER/REMITTANCE ADVICE (HIPAA 835 TRANSACTION)

Providers, who submit their claims electronically, can receive an electronic file containing their Weekly Provider Electronic Remittance Advice/Register. The provider's software system can be programmed so that the ERA can be uploaded into an automated posting system, thus eliminating a number of manual procedures. The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.

For more information, please contact our EDI Services.

ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT) is a provider service where Blue Cross deposits your payment directly into your checking account. EFT, like iLinkBlue, is a free service to providers. With iLinkBlue, you will have access to EFT notifications and payment registers (that can be printed directly). EFT eliminates the mail time associated with the delivery of your payment register and check, as well as the time consuming task of making a manual deposit to your bank.

All Blue Cross providers who sign up for iLinkBlue, must also be a part of our EFT program. In the future, Blue Cross plans to implement mandatory use of the EFT program for all providers.

Blue Cross has created a guide for completing the EFT Application form. The guide as well as the EFT Application form are included in this manual.

To initiate EFT, please complete the EFT Application form located on our Provider Page and submit it to Provider Credentialing and Data Management.