SECTION 6: OTHER COVERAGE
of the Professional Provider Office Manual

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This section provides information about other coverage. 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 6: OTHER COVERAGE

COORDINATION OF BENEFITS

Coordination of benefits (COB) applies to members who are covered by more than one health insurance plan.

When COB is involved, claims should be filed with the primary health insurance carrier first. When an explanation of benefits (EOB) is received from the primary health insurance carrier, the claim then should be filed with the secondary health insurance carrier, attaching the primary carrier's EOB.

If claims are filed with the primary and secondary health insurance carriers at the same time and Blue Cross is the secondary carrier, Blue Cross will suspend claims and request other coverage information from the member. If the primary carrier's EOB is not obtained or the member does not provide a response to our Other Coverage Questionnaire, Blue Cross will deny the claim within 21 days. Once a rejection appears on the Payment Register/Remittance Advice, the patient may be billed for the total charge.

You can assist in the COB process by indicating your Blue Cross patients' other coverage information in Block 9 on the CMS-1500 claim form and Block 50 on the UB-04 claim form. In addition, BCBSLA's Other Coverage Questionnaire is available online on our Provider page. Please provide this form to any patient who has other health insurance coverage.

Medicare Primary Coordination of Benefits for OGB

For OGB members, Blue Cross coordinates with Medicare like we do with any other carrier that is the primary carrier.

SUBROGATION

Subrogation is defined in the Blue Cross member contracts. Subrogation allows health insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third-party. The third-party's liability insurance carrier normally makes these payments. A third party is another carrier, person or company that is legally liable for payment from the treatment of the claimant's illness or injury.

All claims submitted to Blue Cross must indicate if they are related to an accident or if work-related injuries or illnesses are involved.

Providers should:

- Not require the Blue Cross member or the member's attorney to guarantee payment of the entire billed charge.
- Not require the Blue Cross member to pay the entire billed charge up front.
- Not bill the Blue Cross member for amounts above the reimbursement amount/allowable charge.

- Charge the member no more than is ordinarily charged other patients for the same or similar service.
- Bill the member only for any applicable cost share (deductible, coinsurance, copayment) and/or noncovered service.

If amounts in excess of the reimbursement amount/allowable charge were collected, you should refund that amount to the member.

Please note that we do not coordinate benefits with third party liability carriers.

EMPLOYMENT-RELATED INJURIES OR ILLNESS

There are generally three types of legal remedies available to members who sustain employment-related injuries or illnesses:

- Workers' Compensation under state law – A state law provides certain benefits to an employee who is injured within the course and scope of employment.
- Longshore and Harbor Workers' Compensation Act (LHWCA) – A federal law that provides for the payment of medical care to employees disabled from on the job injuries that occur on the navigable waters of the United States, or in adjoining areas, customarily used in loading, unloading, repairing or building of a vessel.
- Jones Act – A federal law that provides remedies only to "seamen" who are injured while working on a vessel.

Blue Cross does not make any coverage determinations as to which legal remedy would apply to a member's injury. All claims for covered services, including those claims for which a third-party may be liable, must be filed directly to Blue Cross. This is important because if the service is determined not to be covered under these legal remedies or the particular contract does not exclude these types of services, you risk any future consideration by failing to meet administrative timely filing requirements by not filing the claims with Blue Cross. Please note that when you do file an initial claim, the current administrative claims process may deny the claim for employment related injuries; however, if it is later determined that the service is not covered by these legal remedies or the particular contract does not exclude these types of services, we encourage and expect you to contact the Customer Care Center so that we can work with your office to apply the appropriate member benefits.

MEDICARE SUPPLEMENTAL CLAIMS

In order to reduce the administrative expense and time involved with manual claims submission, in most cases, Medicare supplemental claims will automatically cross over to Blue Cross and you do not need to file a claim for the Blue Cross portion to be processed.

For BlueCard BCBS Members

Blue Plans may receive crossover claims for providers who are not within their state boundaries. All claims for BlueCard members will be processed by the BlueCard member's Plan listed on the member ID card.

Provider Information at Medicare and Blue Cross

To further ensure eligible Medicare supplemental claims cross over from Medicare to Blue Cross successfully, please notify us immediately of the following:

- If you have a new Tax ID number, or
- If you have not previously given Blue Cross your NPI, you must do before filing claims including your NPI. The Claims Submission section of this manual includes instructions for notifying Blue Cross of your NPI.

How to Determine if the Claim was Crossed Over from Medicare

If a claim is crossed over, you will receive a message beneath the patient's claim information on the Payment Register/Remittance Advice that indicates the claim was forwarded to the carrier.

Example 1: "Claim information forwarded to: BCBS of Louisiana-Supplemental

Example 2: "Claim information forwarded to: BCBS of Alabama

When a Medicare claim has crossed over, providers are to wait 30 calendar days from the Medicare remittance date before submitting a claim to Blue Cross and Blue Shield of Louisiana. Claims you submit to the Medicare intermediary will be crossed over to Blue Cross only after they have been processed by Medicare. This process may take approximately 14 business days to occur. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days from the crossover for you to receive payment or instructions from Blue Cross.

If the remittance does not contain a message similar to the above, the claim was not crossed over to the payor. The participating provider must then file the claim along with a copy of the Medicare Remittance Advice. This claim must be filed on paper to the Plan listed on the member ID card.

The following claims are excluded from the crossover process for Blue Cross:

- Original Medicare claims paid at 100%
- 100% denied claims with no additional beneficiary liability
- Adjustment claims that are non-monetary/statistical
- Medicare Secondary Payer (MSP); claims for which other insurance exists for beneficiary
- National Council for Prescription Drug Programs (NCPDP) claims

When the Claim WAS NOT Crossed Over from Medicare

For Louisiana claims that did not crossover automatically (except for Statutory Exclusions), the provider should wait **31 days** from the date shown on the Medicare remittance to resubmit the claim. Claims submitted before 31 days will be rejected on the Blue Cross and Blue Shield of Louisiana Not Accepted Report.

After 31 days, the claim that did not crossover can be submitted electronically in the 837 format (if sending through a clearinghouse, verify your clearinghouse allows the electronic submission of these claims) or on a paper claim form (CMS-1500 or UB-04) along with a copy of the Medicare remittance advice.

Follow-up on Crossover Claims

Blue Cross Blue Shield of Louisiana:

- Wait 21 days before conducting follow-up on iLinkBlue

Blue Cross Blue Shield out-of-state plans:

- Wait 30 days before contacting the out-of-state plan

Services Excluded or Not Covered by Medicare

When a charge is considered excluded or not covered, providers are not required to wait the 31 days to file the claim. The claim should contain Modifier GY with the specific, appropriate, HCPCS code, if available. If there is not a specific HCPCS code, a not otherwise classified (NOC) code must be used with Modifier GY.

These claims can be filed electronically or on paper to Blue Cross and Blue Shield of Louisiana.

Medicare Payment Rules for Consultation Services

Medicare no longer recognizes consultation CPT codes 99241-99245 and 99251-99255. This applies for both Medicare-primary and Medicare-secondary claims.

Please Note: We have current allowable charges for these codes and any changes in allowable amounts or billing policies for these codes will be communicated to our providers with a 90-day notice. At this time, we do not anticipate any changes.

Per CMS, physicians and others must bill an appropriate E&M code for the services previously paid using the consultation codes. If the primary payer for the service continues to recognize consultation codes, physicians and others billing for these services may either:

1. Bill the primary payer an E&M code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with the same E&M code, to Medicare for determination of whether a payment is due; or
2. Bill the primary payer using a consultation code that is appropriate for the service, and then report the amount actually paid by the primary payer, along with an E&M code that is appropriate for the service, to Medicare for determination of whether a payment is due.

Please Note: The first option may be easier from a billing and claims processing perspective.

For more on this from CMS, visit their website.

If you have any questions or require additional information on Medicare supplemental claims, please contact Customer Care Center.

Medicare Benefit Exhaust Claims Requirements

Member has Medicare Parts A & B

When a member has Medicare Parts A & B and has exhausted Part A benefits in the middle of a hospital admission or the entire hospital admission is exhausted, the required information for Medicare exhaust claims should include the following:

- UB-04 claim form with Medicare Part A charges and the paid/exhausted Medicare EOB that matches these charges
- UB-04 claim form for Medicare Part A charges beginning with the date Medicare benefits were exhausted. It cannot include dates before the exhaust date
- Copy of medical records
- UB-04 claim form with Medicare Part B charges after the exhaust date and the Medicare EOB that matches these charges

Member has Medicare Part A only

When a member has Medicare Part A only and has exhausted Part A benefits in the middle of a hospital admission or the entire admission is exhausted, the required information for Medicare exhaust claims should include the following:

- UB-04 claim form with Medicare Part A charges and the paid/exhausted Medicare EOB that matches these charges
- UB-04 claim form for Medicare Part A charges beginning with the date Medicare benefits were exhausted. It cannot include dates before the exhaust date
- Copy of medical records

Member has Medicare Part B only

When a member has Medicare Part B only the provider should file two claims. (The Part A claim will come to Blue Cross for primary payment. The Part B claim will be sent to Medicare for primary payment. Once Medicare B has processed, then the claim will be filed to Blue Cross with a copy of the MEOB that matches the charges billed for secondary payment.)

The Part A claim must include the following:

- UB-04 form not to include any Part B charges
- Copy of medical records