SECTION 8: CLAIMS RESOLUTIONS
of the Professional Provider Office Manual

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This section provides information about claims resolutions. 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 8: CLAIMS RESOLUTIONS

SUBMITTING ACTION REQUESTS TO RESOLVE CLAIMS ISSUES

Submitting an action request through iLinkBlue is a great option for getting a quick and accurate resolution for your claims issues. Action requests:

- Reduce the time it takes for providers to receive a response from Blue Cross
- Allow providers to see responses directly from the adjustments team after review
- Allow providers to submit additional questions once they have reviewed the action request response

Common Reasons to Submit an Action Request

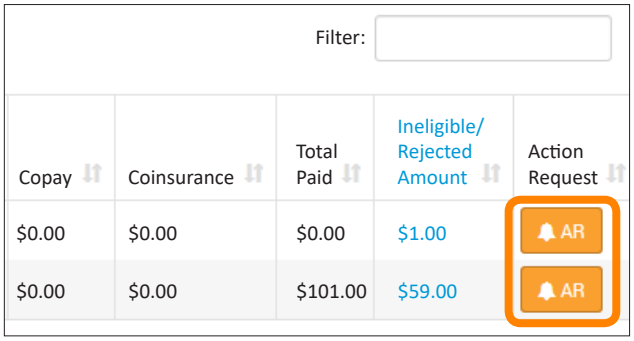
Action requests allow you to electronically communicate with Blue Cross when you have questions or concerns about a claim. This can include:

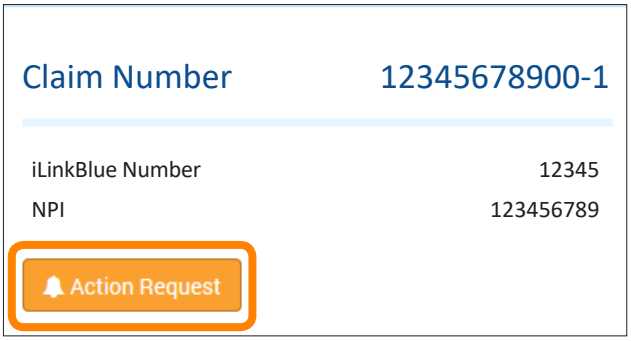
- Claim status (detailed denials)
- Claim denied for coordination of benefits
- Claim denied as duplicate
- Claim denied for no authorization (but there is a matching authorization on file)
- Information needed from member (coordination of benefits, subrogation)
- Questioning non-covered charges
- No record of membership (effective and term date)
- Medical records receipt
- Recoupment request
- Status of an appeal
- Status of a grievance

Please Note: Action requests do not allow you to submit documentation regarding your claims review.

Submitting an Action Request through iLinkBlue

On each claim researched through the Claim Status search tool in iLinkBlue, providers have the option to submit an action request to request a review for correct processing. Click the "AR" button from the Claims Results screen or the "Action Request" button from the Claim Details screen to open a form that prepopulates with information on the specific claim. Please include your contact information. You only have to do one action request per claim; not one action request per line item of the claim.





When submitting an action request

- Request a review for correct processing
- Be specific and detailed
- Allow 10-15 business days for first request
- Check iLinkBlue for a claims resolution
- Submit a second action request for a review
- Allow 10-15 business days for second request

If you have followed the steps outlined here and still do not have a resolution, you may contact Provider Relations for assistance at provider.relations@bcbsla.com. Email an overview of the issue along with two action request dates OR two customer service reference numbers if one of the following applies:

1. You have made at least two attempts to have your claims reprocessed (via an action request or by calling the Customer Care Center) and have allowed 10-15 business days after second request, or
2. It is a system issue affecting multiple claims.

CLAIMS RESUBMISSION (OR REFILING)

When a claim is refiled for any reason, ALL services should be placed on the claim. For example, it is inappropriate to refile a claim with only one procedure when more than one procedure was placed on the initial claim. Splitting the claim may cause adjustments to be performed.

ADJUSTMENT AND VOID CLAIM SUBMISSIONS

Adjustment and void claims can be submitted on any claim that has completed the processing cycle and appears on your Remittance Advice. The claim number assigned on the remittance will be needed to submit an adjustment or void claim.

Void Claim – The submission of a void claim is requesting that the entire claim be removed, and any payments or rejections be retracted from the member and provider's records.

Adjustment Claim – The submission of an adjustment claim requests that a previously processed claim be changed (information or charges added to, taken away or changed).

Electronic (837I & 837P) Adjustment and Void Claims

Adjustments and void claims can be submitted for all changes except for changes to the member ID number or pay-to-provider number. If these fields require change, you must submit the claim on paper, clearly indicating the old information and new information (pay-provider number and/or member ID number).

To submit these claims, you first obtain the claim number found on the payment register/remittance advice. This claim number will be used in the ICN (internal control number) field.

Ensure the accurate electronic (837I or 837P) submission by following the instructions below:

Adjustment Claim

- Enter the frequency code "7" in loop 2300 Segment CLM05-03.
- Enter the 10-character ICN of the original claim (assigned on the processed claim) in loop 2300 in an REF segment and use F8 as the qualifier.

Note: The adjusted claim should include all charges (not just the difference between the original claim and the adjustment).

Void the Claim

- Use frequency code "8" in loop 2300 Segment CLM05-03.
- Use the 10-character ICN of the original claim (assigned on the processed claim) in loop 2300 in an REF segment and use F8 as the qualifier.

iLinkBlue Professional CMS-1500 Adjustment and Void Claims

- Field 19A Professional Claim Adjustment/Void Indicator is required:
  A - Adjust original claim
  V - Void original claim
- Field 19B Internal Control Number (ICN Number) – The ICN Number is the claim number from the BCBSLA Remittance Advice (Provider Payment Register).

OVERPAYMENTS

We accept notification of overpayments for Blue Cross, HMOLA, FEP and BlueCard® (out-of-area) members. If you believe an overpayment has occurred on a claim, it is important to notify us of the suspected overpayment.

- For BCBSLA, HMOLA and FEP members, we can accept a payment with your notification of the overpayment
- For BlueCard members, do not send a check or payment with your notification. Submit the notification only. All adjustments will be reflected on your future payment register(s).

You may submit overpayment notifications to Blue Cross in one of the following ways:

Submit an Action Request through iLinkBlue (preferred method)

Go to the claim thought to be overpaid in iLinkBlue and submit an action request to have the claim reviewed for correct processing. To do this, click the "AR" button from the Claims Results screen or the "Action Request" button from the Claim Details screen to open a form that prepopulates with information on the specific claim. Please include your contact information. Please only submit one action request per claim; not one action request per line item of the claim. For more information on this process, please refer to our *iLinkBlue User Guide*, available online at www.BCBSLA.com/providers >Resources >Manuals.

Submit an Overpayment Notification Form

A printable version of this Overpayment Notification Form is available online at www.BCBSLA.com/providers >Resources >Forms. A sample of the form is also available in the Forms section of this manual.

For BlueCard members, do not send a check (payment) with this form. Submit the form only. All adjustments will be reflected on your future payment register(s). BCBSLA cannot accept payments for BlueCard members. If an unsolicited refund payment is received for a BlueCard member, it will be returned with a letter requesting an Overpayment Notification Form be submitted. You may instead submit an Action Request in lieu of the form.

Upon submitting the form:

- If it is determined that an overpayment did occur, you will not receive further notification from us. The claim will be adjusted, and your payment register will reflect the change.
- If it is determined that an overpayment did not occur, you will receive notification explaining that no adjustment to the claim is necessary.

When BCBSLA discovers the overpayment:

- If it is determined that a provider has received an overpayment and has not yet informed us, Blue Cross will send notification requesting the provider respond either agreeing to or appealing the overpayment within 30 days. For FEP members, the provider has 120 days to respond.

- After the applicable provider review period, the claim is adjusted and will be reflected on the provider's future payment register(s).

Please Note: Provider should actively work credit balances due to Blue Cross and return overpayments to Blue Cross. Refunds greater than $10,000 should be identified back to Blue Cross within 120 days from the occurrence date. This should be done even when credit balance recovery vendors are assisting with this process. Failure to do so may result in the provider being responsible for the fees incurred for the recovery.

REFUNDS PROCESS

There may be times when Blue Cross must request refunds of payments previously made to providers. When refunds are necessary, Blue Cross notifies the provider of the claim in question 30 days prior to any adjustment. The notification letter explains that Blue Cross will deduct the amount owed from future Payment Registers/Remittance Advices unless the provider contacts us in writing within 30 days. Recoveries and payments for omissions and underpayments shall be initiated within 15 months of the date of the payment of the claim. Blue Cross and the participating provider agree to hold each other and the member harmless for underpayments or overpayments discovered after 15 months from the date of payment.

If Blue Cross returns a claim or part of a claim for additional information, providers must resubmit it within 90 days or before the timely filing period expires, whichever is later.

If Blue Cross has made any omissions or underpayments, the Plan will make payment for such errors as soon as they are discovered or within 30 days of written notice from the participating provider regarding the error.

We make every effort to pay claims in a timely manner; however, when a clean claim is not paid on time, we follow the late payment penalty guidelines outlined in House Bill 2052/Regulation 74. Providers automatically receive penalty payment for claims that are not processed in the time frames set forth by House Bill 2052/Regulation 74. The additional payment will almost always appear on the same payment register/remittance advice as the claims payment and can be identified by the status code "ST, Statutory Adjustment."

Please Note: House Bill 2052/Regulation 74 does not apply to FEP, self-insured plans, insured ERISA plans, worker's compensation plans or state employee group benefit programs. Also, the late payment penalty does not apply if the claim is delayed through the fault of the claimant.

MEMBER REFUNDS

Member refunds should be based on actual payment(s) made by Blue Cross when there are two primary payers (no COB). The member's coinsurance, lifetime benefits and premiums are based on the reimbursement amount paid to the member provider. The above allowable charge amount (contractual allowance) should not be part of the member refund.

PROVIDER DISPUTES

Blue Cross recognizes there may be times when participating providers disagree with the way a claim was adjudicated. If a claim issue cannot be resolved through an action request or by your Provider Relations representative, then a claims dispute may be needed. This is different than an appeal or grievance. Disputes are defined as written requests from our participating network providers questioning (or disputing) a processed claim may include one of the following reasons:

- Reimbursement concerns (the allowed amount vs. the above allowable amount, which the provider must write off)
- Authorization penalties where the provider is liable for the amount
- Claim check/bundling issues (note: first time reviews for claim check and bundling issues should be submitted as an action request for review)
- Maximum daily benefit denials
- Timely filing denials
- Refund disputes

Please refer to the "A Guide for Reviewing Claims" provider tidbit for complete information on submitting claims information for review to ensure it is routed to the appropriate area of the company. The guide lists the information Blue Cross needs and where to send it. The tidbit is available in the "Resources" section of our Provider page. A sample Appeals and Provider Dispute Form is available in Appendix II Forms at the end of this manual.

MEMBER APPEALS

Medical appeals involve an adverse benefit determination based on medical necessity, appropriateness, healthcare setting, level of care, or effectiveness or is determined to be experimental or investigational. All other appeals are considered administrative appeals.

Member appeals processes vary due to variations in state and federal laws. We will apply the law that governs the benefits purchased by the member or the member's employer. There are some plans that are not governed by either the state laws or the federal laws. The member's health plan describes the appeals processes applicable to the member. Below outlines a general description of the appeal process. If there is a discrepancy between the member's health plan and what is described below, the member's health plan will control.

Standard Medical Appeals

The member, their authorized representative, or a provider authorized to act on the member's behalf, must submit a written request to appeal within 180 days following the member's receipt of an initial adverse benefit determination. Requests submitted to us after 180 days of our initial determination will not be considered.

If our initial denial is overturned on the member's medical appeal, we will process the claim and will notify the member and all appropriate providers, in writing, of the internal appeal decision. If our initial denial is upheld, we will notify the member and all appropriate providers, in writing, within 30 days of the member's request; unless the member or their authorized representative and we mutually agree that an extension of the time is warranted. At that time, we will inform the member of their right to begin the external appeal process if the claim meets the criteria.

If the member still disagrees with our determination on their claim following the internal review process, the member or their authorized representative may request an external appeal conducted by a non-affiliated Independent Review Organization (IRO). The member must send their written request for an external appeal, within 120 days* of receipt of the internal appeal decision. The member must grant permission for the request of an external review by completing and submitting at the time of external appeal request the form "I want to ask for an external appeal." Any external review requested without the required form will not be considered.

We will provide the IRO all pertinent information necessary to conduct the appeal. The IRO decision will be considered a final and binding decision on both the member and us. The external review will be completed within 45 days of our receipt of the request and the IRO will notify the member or their authorized representative and all appropriate providers of its decision.

** Requests submitted to us after 120 days of receipt of the internal appeal decision will not be considered.*

Tips for Completing Standard Medical Appeals

- Complete all information on the Provider Appeal Request Form (including contact information in case additional records are needed) that was included in the initial denial notice. Incomplete information may delay the review.
- Clearly identify service being appealed (ex: drug name, specific procedure, DME item, etc.).
- Include supporting rationale and supporting clinical records.
- Please read the "What can you do if you still disagree with our decision?" section of the initial denial letter and appeal denial letter for the appropriate appeal timeframes and instructions for the member's policy.
- We require network providers to disclose ineligible services to members prior to performing or ordering services. Our medical policies are available on iLinkBlue. Benefit determinations are made based on the medical policy in effect at the time of service.

Please Note: Peer-to-peer reviews are not available once an appeal has been initiated.

Expedited Appeals

We provide an expedited appeal process for review of an adverse determination involving a situation where the time frame of the standard appeal would seriously jeopardize the member's life, health or ability to regain maximum function. It includes a situation where, in the opinion of the treating physician, the member may experience pain that cannot be adequately controlled while awaiting a standard internal appeal decision or a non-certification determination concerning an admission, availability of care, continued stay, or health care service for a covered person or his authorized representative who is requesting emergency services or has received emergency services but has not been discharged from a facility. Expedited appeals are not provided for services previously rendered.

The expedited appeal process allows for expedited appeal decisions no later than 72 hours of our receipt of an expedited appeal request that meets the criteria for expedited appeal.

In any case where the expedited internal appeal process does not resolve a difference of opinion between us and the covered person or the provider acting on behalf of the covered person, the appeal may be elevated to an expedited external appeal, if appropriate. In such cases, we will forward all pertinent information for expedited external appeal requests to the IRO so the review may be completed within 72 hours of receipt.

Please Note: Although submission of additional information is not required at the time an appeal request is requested, an explanation and/or supporting documentation for an appeal is recommended.

Multiple requests to appeal the same claim, service, issue or date of service will not be considered, at any level of review.

Tips for Completing Expedited Appeals

- If submitting with the appeal form included in the initial denial letter, the physician must clearly mark the form as "Expedited" (urgent) and sign the attestation that requested service meets the expedited criteria.
- Fax the expedited appeal request along with supporting documentation to the number found on the Quick Reference Guide in the front of this manual.

Standard Administrative Appeal

Administrative appeals involve contractual issues and are typically submitted by the member or someone on behalf of the member (including providers), **with the member's authorization**.

The top reasons for administrative appeals are:

1. Out-of-network (OON) providers
2. Contract limitations or exclusions
3. Claims processing (how cost sharing was applied)

First Level Administrative Process

If the member is not satisfied with our claims decision (adverse benefit determination), the member, their authorized representative or a provider acting on their behalf (with signed authorizations from the member), must submit a written request to appeal within 180 days following the member's receipt of an initial adverse benefit determination. Appeals should be submitted in writing to the addresses found on the Quick Reference Guide in the front of this manual.

Please Note: Requests submitted to Blue Cross after 180 days of the denial will not be considered.

We will investigate the member's concerns. If we change our original decision at the appeal level, we will process the member's claim and notify the member and all appropriate providers, in writing, of the first level appeal decision. If our initial claims decision is upheld, we will notify the member and all appropriate providers, in writing, of our decision within 30 calendar days of the member's request; unless we mutually agree that an extension of the time is warranted. At that time, we will inform the member of the right to begin the second level appeal process, if applicable.

Second Level Administrative Process (If Applicable)

Within 60 calendar days of the date of our first level appeal decision, a member who is not satisfied with the decision may initiate the second level of appeal process. Requests submitted to us after 60 days of the denial will not be considered.

A member appeals committee not involved in any previous denial will review all second level appeals. The committee's decision is final and binding as to any administrative appeal and will be mailed to the member within five days of the committee meeting.