



New Claims Editing Software (Facility)

Summer 2019

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Today's Presenter



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Provider Relations



New Claims Editing Software



- We are updating to a new claims editing software (CES) system
- In this webinar, we will cover what you need to know about the new software and how it may affect your claims

CES Features

- Enables us to effectively and consistently manage healthcare delivery and reimbursement by identifying potentially incorrect coding relationships on submitted claims
- Some policies have been updated based on industry-recognized rules and to be aligned closer to Medicare
- Changes will be based on a combination of national coding edits, CPT guidelines, specialty society guidelines, clinically-derived edits and federal regulations and policies governing healthcare claims



What Is It?

Claims editing that is applied to incoming claims to ensure proper coding and billing based on:

- Reimbursement
- Medical Policy
- Benefits Rules
- Industry Standard Coding Guidelines

What Does It Do?

- Promotes accurate and consistent payments
- Manages compliance with standard coding and billing practices between various types of services, such as:
 - Medical
 - Surgical
 - Lab and Radiology



What Impact Will You Notice?



- Many of the existing edits will remain the same; however, there will be some differences to conform to changes in coding standards, updated reviews of existing code editing logic and enhanced functionality of the new system
- There may be changes in your payments due to how claims are properly processed and priced as a result of this update
- This may also change the look of your payment register



When Does it Launch?

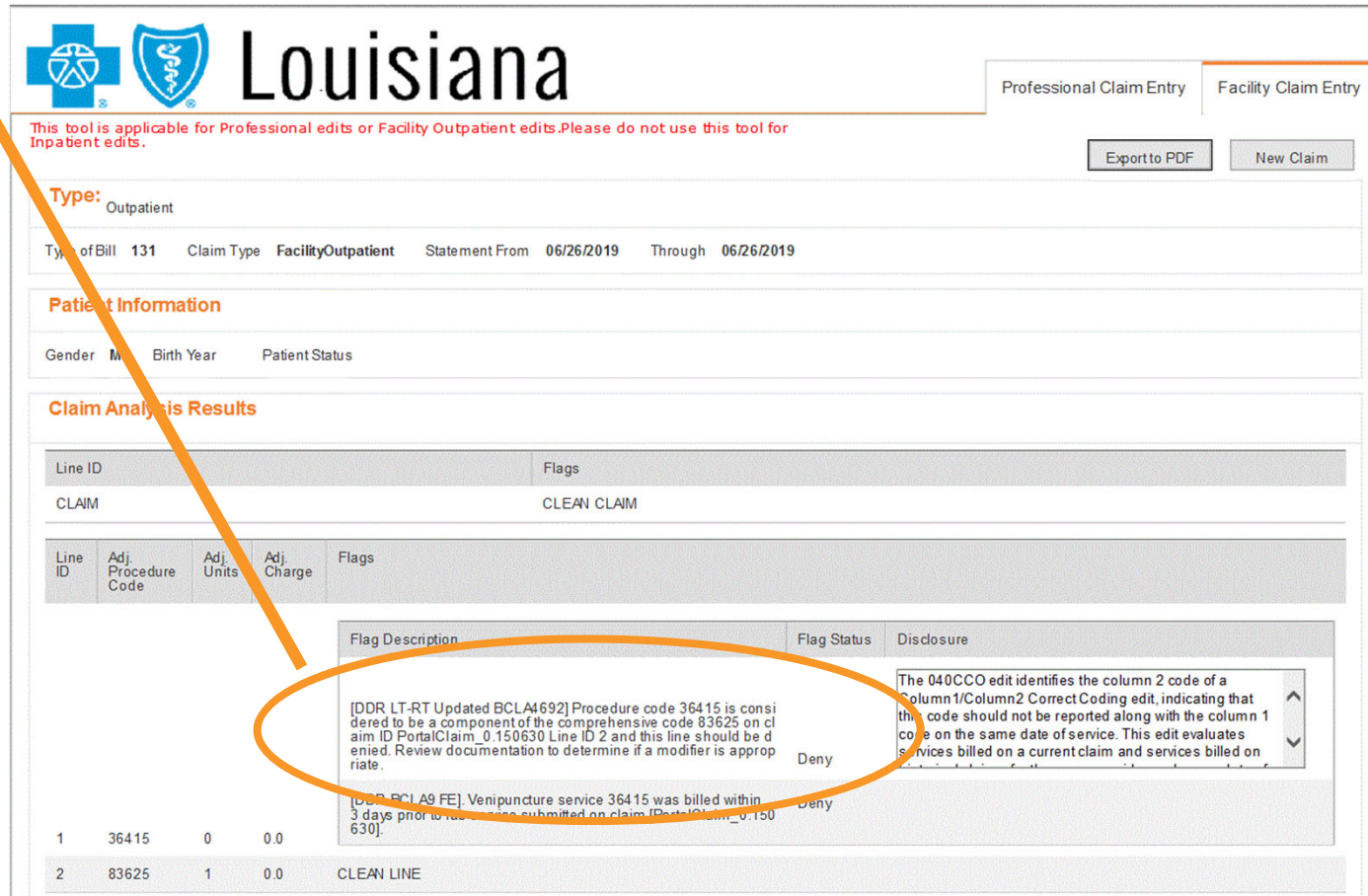


Examples of Changes



Bundling, Incidental & Mutually Exclusive Edits

Example: CPT Code 36415 is considered to be a component of the comprehensive code 83625



Louisiana Professional Claim Entry Facility Claim Entry

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Export to PDF New Claim

Type: Outpatient

Type of Bill 131 Claim Type FacilityOutpatient Statement From 06/26/2019 Through 06/26/2019

Patient Information

Gender M Birth Year Patient Status

Claim Analysis Results

Line ID	Flags
CLAIM	CLEAN CLAIM

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	36415	0	0.0	[DDR LT-RT Updated BCLA4692] Procedure code 36415 is considered to be a component of the comprehensive code 83625 on claim ID PortalClaim_0_150630 Line ID 2 and this line should be denied. Review documentation to determine if a modifier is appropriate. Deny
2	83625	1	0.0	CLEAN LINE

Flag Description: [DDR LT-RT Updated BCLA4692] Procedure code 36415 is considered to be a component of the comprehensive code 83625 on claim ID PortalClaim_0_150630 Line ID 2 and this line should be denied. Review documentation to determine if a modifier is appropriate.

Flag Status: Deny

Disclosure: The 040CCO edit identifies the column 2 code of a Column1/Column2 Correct Coding edit, indicating that this code should not be reported along with the column 1 code on the same date of service. This edit evaluates services billed on a current claim and services billed on



Max Frequency

Updated list of codes and related number of units allowed on the same date of service

Example: an allowed daily frequency of 1 has been exceeded by 29



Modifiers



Updated rules applied for modifiers to be consistent with industry-recognized rules. i.e., modifiers appropriate to use with evaluation and management (E&M) codes, modifiers appropriate to use with site-specific codes, etc.

Modifier 50

Codes that allow Modifier 50 has been updated. When billing with Modifier 50, only **one unit per line** should be billed. Additional units will be reduced to 1, and approved reimbursement will be for 1 unit only per each line.

Note: When billing multiple bilateral procedures, each would be identified and billed with Modifier 50 on separate lines, with a unit of 1 per each line

Multiple Procedure Reduction

Codes exempt from Multiple Procedure Reduction have been updated

Note: This edit is based on date of service on and after August 1, 2019

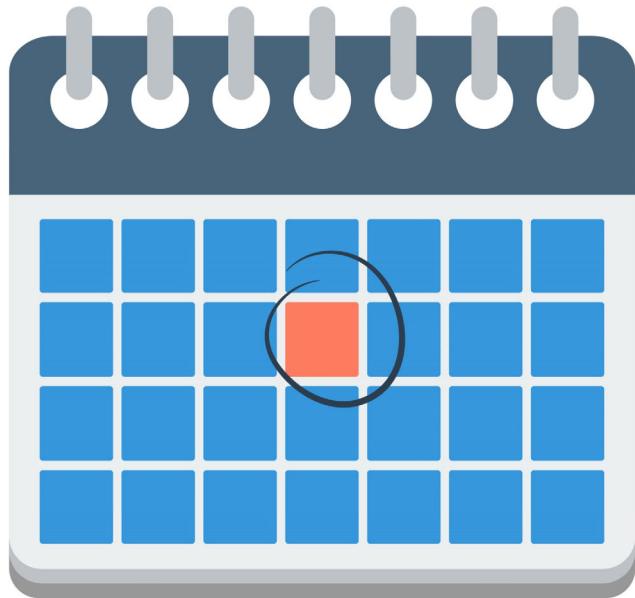
A listing of the codes exempt from Multiple Procedure Reduction can be found on iLinkBlue (www.BCBSLA.com/ilinkblue) > Claims > Claims Editing System

The following medical codes are exempt from the multiple procedure discount as defined in the Reimbursement Appendix of the Member Provider Agreement. This means they will be reimbursed at 100% of the reimbursement amount. These codes are subject to change.

32553	38242	92961
36440	38243	0269T
36450	38999	026AT
36455	43755	026ST
36456	49411	0434T
36460	50686	0435T
36511	51101	0438T
36512	51703	0512T
36513	51784	0548T
36514	53660	C3728
36516	54240	G0277
36522	58576	
38206	62352	
38207	62367	
38208	62368	
38209	62369	
38210	62370	
38211	67028	
38212	91020	
38213	91030	
38214	91132	
38215	91209	
38230	92242	
38232	92950	
38241	92960	

MEMBER SERVICE
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Not Separately Reimbursable



Certain codes will be denied because these services should be included with other services billed on the same day

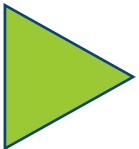
Examples: Codes billed for general surgical supplies, quality measure codes (e.g., 0001F-9000F)

Rebundles

Individual lines will be denied when two or more component codes are billed instead of a more appropriate, comprehensive code. The provider will need to refile the correct, comprehensive code.

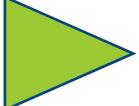
Examples:

80053
84443
85025




80050

73560
73562




73564

85025
86592
86762
86850
86900
86901
87340



80055

85025
86592
86762
86850
86900
86901
87340
89389



80081

Important Things to Remember



- Most edits are based on date processed, **not** date of service*
- Any claim adjustments processed **after the implementation date** of the new CES system will be subject to edits in the new system
- **Explanation codes and descriptions** on payment register may be different in the new system

*With the exception of Multiple Procedure Reductions and Max Frequency

Troubleshooting

If you do not understand the way your claim was processed follow these steps to troubleshoot



Troubleshooting

Step 1

Check that you are following the proper billing guidelines. Refer to resources in your:

- Provider Manual
- Code Book
- Lists provided on iLinkBlue, etc.

Step 2

Check the new CES provider portal tool to determine if the CES system is processing according to the new edits based on the rejection code. (CES edits will appear in lower case.)

How to Inquire

Step 3

Submit an Action Request

- In order to properly route your inquiry please choose "**Code Editing Inquiry**" from the action drop down box when submitting your action request
- Please include your contact information
- Be specific and detailed
- Allow up to 15 working days for a response to each request
- Check in "Action Request Inquiry" for a response
- A second request may be submitted if there was no resolution




How to Inquire

Step 4

Review the **"A Guide for Disputing Claims"** tidbit for proper steps in order to dispute a claim

Supporting our providers and their staff.

TIDBITS

 Louisiana

A Guide for Disputing Claims

Providers should use the chart on this guide when submitting claims information to ensure it is routed to the appropriate area of the company. This chart lists the best way to respond (and not respond) when providers submit claim information for review, and where to send the information so the end results are a quick and efficient claims review process.

For corrected claims, please review our Corrected Claims Tidbit, available at www.BCBSLA.com/providers > Resources > Tidbits.

Claims Issue	What to Submit	What NOT to Submit	Where to Send
Medical records requested or denied for insufficient medical information	<ul style="list-style-type: none">Supporting medical documentation & copy of Blue Cross letter of request for medical records	<ul style="list-style-type: none">Appeals and Claims Dispute FormClaim Form	BCBSLA - Medical Records P.O. Box 98031 Baton Rouge, LA 70898-9031
Claim rejected as a duplicate	<ul style="list-style-type: none">ILINKBlue Action RequestSupporting medical documentation	<ul style="list-style-type: none">Appeals and Claims Dispute FormLetter of appeal or Appeal Request Form	www.BCBSLA.com/linablu or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Authorization penalty when authorization was obtained	<ul style="list-style-type: none">ILINKBlue Action RequestCall Customer Care Center	<ul style="list-style-type: none">Written request	www.BCBSLA.com/linablu or refer to the customer service number listed on the back of the member ID card
Claim denied for primary carrier's explanation of benefits (EOB)	<ul style="list-style-type: none">Claim with EOB from primary carrier	<ul style="list-style-type: none">Appeals and Claims Dispute FormLetter of appeal or Appeal Request Form	www.BCBSLA.com/linablu or BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029
Claim denied for a BlueCard® MEMBER (found through a Blue Plan either from Blue Cross and Blue Shield of Louisiana)	<ul style="list-style-type: none">Appeals and Claims Dispute Form*Formal letter of appeal including reasonSupporting medical documentation	<ul style="list-style-type: none">Claim FormAppeal Request Form	BCBSLA P.O. Box 98029 Baton Rouge, LA 70898-9029 or Fax to (225) 297-2727

*The Appeals and Claims Dispute Form is available at www.BCBSLA.com/providers > Resources > Forms. [More](#) →

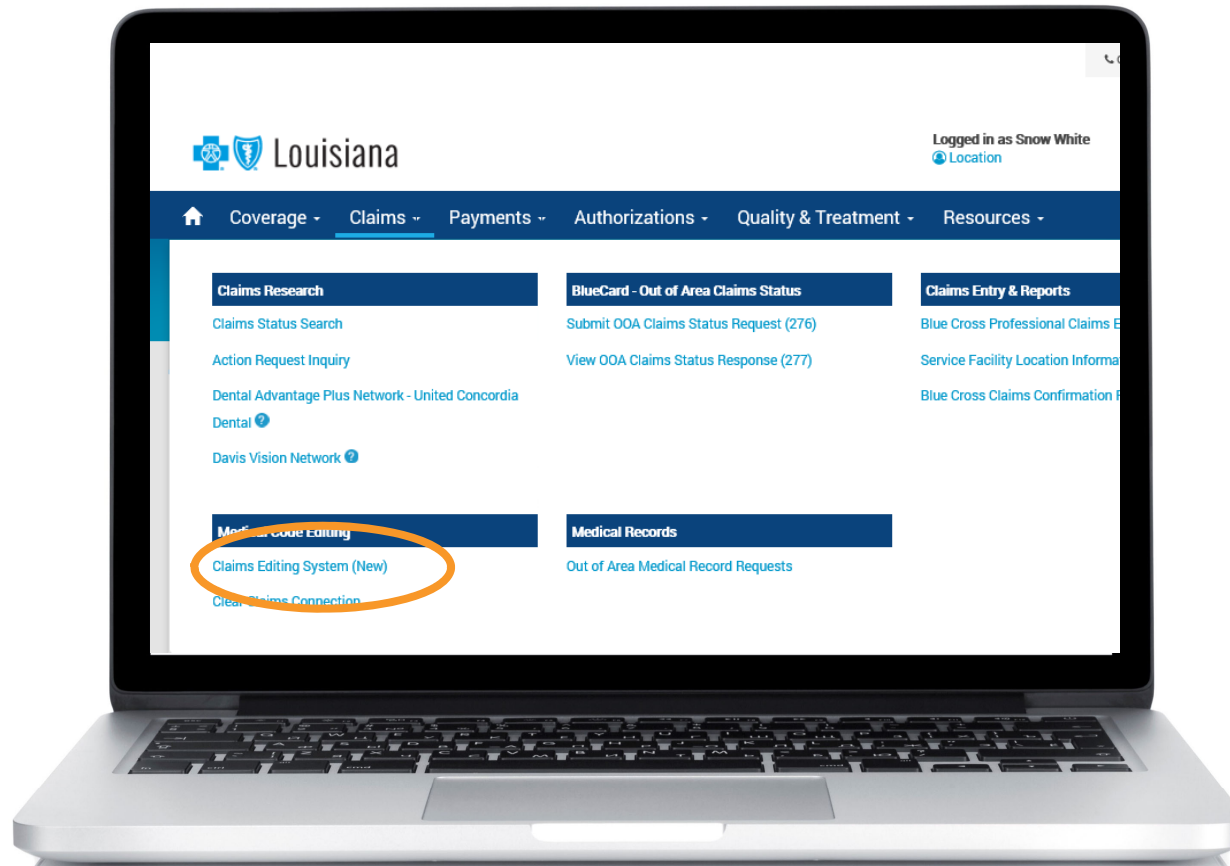
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www.BCBSLA.com/providers > Resources > Tidbits

New CES Provider Portal Tool

With the implementation of the new CES system, we have a new tool in iLinkBlue for providers to calculate claim edit outcomes



This new CES tool will replace the Clear Claims Connection tool

CES Provider Portal Tool

The new CES tool is available for both **outpatient facility** and **professional** claims. Please make sure you select the correct tab as the edits and modifiers will not be the same.

Louisiana
This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry | Facility Claim Entry

Type Inpatient Outpatient

Type of Bill Claim Type Statement From Through Admit Date Admit Type

Patient Information

Gender Date of Birth Patient Status

Add Lines

Line	HOPCSHIPPS	Modifier	Date	Units
1	<input type="text"/>	<input type="text"/>	<input type="text" value="06/27/2019"/>	<input type="text" value="1"/>
2	<input type="text"/>	<input type="text"/>	<input type="text" value="06/27/2019"/>	<input type="text" value="1"/>
3	<input type="text"/>	<input type="text"/>	<input type="text" value="06/27/2019"/>	<input type="text" value="1"/>

Diagnoses

Diagnosis	Code	POA
Principal	<input type="text"/>	<input checked="" type="checkbox"/>
Admitting	<input type="text"/>	<input checked="" type="checkbox"/>

Procedures

Principal

Other Codes

Add Other

Procedure	Code	Date
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CES Provider Portal Tool

This tool applies to **hospital outpatient & ambulatory surgery center claims only** and does not guarantee claims payment.



The results of the software do not consider all circumstances and factors that may affect payment including:

- Historical claims previously billed
- Multiple procedure reduction
- Member benefits and eligibility
- Provider contracts
- Modifiers that override edits
- Max frequency edits

CES Provider Portal Tool

Mandatory Fields

The screenshot shows the Louisiana CES Provider Portal Tool interface. At the top left are the logos for the state of Louisiana and the Department of Health and Hospitals. The title "Louisiana" is prominently displayed. On the right, there are tabs for "Professional Claim Entry" and "Facility Claim Entry", with "Facility Claim Entry" being the active tab. Below the tabs is a "Submit" button. A red warning message states: "This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits." The main form area includes a "Type" section with radio buttons for "Inpatient" and "Outpatient", where "Outpatient" is selected. Below this are fields for "Type of Bill", "Claim Type" (a dropdown menu currently showing "FacilityOutpatient"), "Statement From", and "Through". The "Patient Information" section includes fields for "Gender" (a dropdown menu showing "Male"), "Date of Birth", and "Patient Status". At the bottom, there is an "Add Lines" button and a table with three columns: "Line", "HCPCS/HIPPS", "Modifier", "Date", and "Units". The table contains three rows, each with a date of "06/26/2019" and a unit value of "1". Several fields are circled in orange to indicate they are mandatory: the "Outpatient" radio button, the "Type of Bill" field, the "Claim Type" dropdown, the "Statement From" and "Through" date fields, the "HCPCS/HIPPS" field in the first row of the table, the "Date" field in the first row of the table, and the "Units" field in the first row of the table.

Type Inpatient Outpatient

Type of Bill Claim Type Statement From Through

Patient Information

Gender Date of Birth Patient Status

Add Lines

Line	HCPCS/HIPPS	Modifier	Date	Units
1	<input type="text"/>	<input type="text"/>	<input type="text" value="06/26/2019"/>	<input type="text" value="1"/>
2	<input type="text"/>	<input type="text"/>	<input type="text" value="06/26/2019"/>	<input type="text" value="1"/>
3	<input type="text"/>	<input type="text"/>	<input type="text" value="06/26/2019"/>	<input type="text" value="1"/>

NOTE: If you do not enter the Statement From or Through dates, the system will process the request without error; however, no edits will be returned, so the dates are necessary

CES Provider Portal Tool Outputs



Louisiana

Professional Claim Entry

Facility Claim Entry

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Export to PDF

New Claim

Type: Outpatient

Type of Bill 131 Claim Type FacilityOutpatient Statement From 06/26/2019 Through 06/26/2019

Patient Information

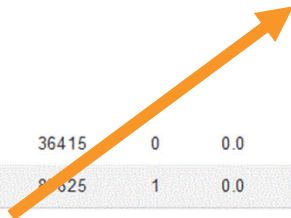
Gender M Birth Year Patient Status

Claim Analysis Results

Line ID				Flags
CLAIM				CLEAN CLAIM

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	36415	0	0.0	
2	83625	1	0.0	CLEAN LINE


Flag Description	Flag Status	Disclosure
[DDR LT-RT Updated BCLA4692] Procedure code 36415 is considered to be a component of the comprehensive code 83625 on claim ID PortalClaim_0.150630 Line ID 2 and this line should be denied. Review documentation to determine if a modifier is appropriate.	Deny	The 040CCO edit identifies the column 2 code of a Column1/Column2 Correct Coding edit, indicating that this code should not be reported along with the column 1 code on the same date of service. This edit evaluates services billed on a current claim and services billed on
[DDR BCLA9 FE]. Venipuncture service 36415 was billed within 3 days prior to lab service submitted on claim [PortalClaim_0.150630].	Deny	



Bundle edit - 36415 denied because it was billed with lab code 83625



CES Provider Portal Tool Outputs

 **Louisiana**

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Professional Claim Entry | Facility Claim Entry

Export to PDF | New Claim

Type: Outpatient

Type of Bill: 131 | Claim Type: Facility Outpatient | Statement From: 06/26/2019 | Through: 06/26/2019

Patient Information

Gender: M | Birth Year: | Patient Status:

Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	92250	0	0.0	

CLAIM: CLEAN CLAIM

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags	Flag Description	Flag Status	Dis closure
1	92250	0	0.0		[DDR BCLA4477] HCPCS code 92250 is inherently bilateral and should not be billed more than once for the same date of service.	Deny	The 017BP edit fires when an inherently bilateral procedure code occurs on more than one line or with more than one unit for the same date of service. This edit applies unless modifier 76 or 77 is submitted on the second or subsequent line or units. Condition code G0 will override edit 17 for inherently bilateral codes with a status indicator of "V." This edit is based on a requirement from the Centers for Medicare & Medicaid Services.

Code Type:

Diagnoses

Diagnosis	Code
Principal	

Reason(s) for Visit

Diagnosis

Original Lines

Line	Rev Code	Modifier	Date	Units
1			06/26/2019	2

Bilateral procedure (92250) billed with 2 units



CES Provider Portal Tool Outputs

Louisiana

Professional Claim Entry | Facility Claim Entry

This tool is applicable for Professional edits or Facility Outpatient edits. Please do not use this tool for Inpatient edits.

Export to PDF | New Claim

Type: Outpatient

Type of Bill: 131 | Claim Type: Facility Outpatient | Statement From: 06/26/2019 | Through: 06/26/2019

Patient Information

Gender: M | Birth Year: | Patient Status:

Claim Analysis Results

Line ID	Adj. Procedure Code	Adj. Units	Adj. Charge	Flags
1	G0463	0	0.0	[DDR BCLA19 FE] Submitted HCPCs code G0463 is not separately reimbursable.

Code Type:

Diagnoses | Reason(s) for Visit

G0463 not separately reimbursable



Questions?



If you have additional questions after this webinar,
please email provider.relations@bcbsla.com.