

Section 4: Billing

Independent Physician and Provider Manual

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Overview

This section outlines Blue Shield's billing procedures and requirements for submitting claims. It describes Blue Shield claims payment policies for specific situations, such as Coordination of Benefits (COB) and major organ transplant billing. It also explains Blue Shield's process for resolving billing issues. Following these procedures and guidelines will help assure error-free processing and timely payments of your claims.

Note: In many instances, Blue Shield's billing procedures and guidelines are identical to those for Medicare. However, it is important for you to become familiar with Blue Shield's unique billing requirements to assure correct and timely payment.

Claims Processing

All Blue Shield-contracted providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

If you do not submit a complete claim in one of these two formats, it may not be accepted or may possibly be denied, and you will need to resubmit the claim in an acceptable format.

Electronic Claims Submission

Providers have several data transfer options for submitting claims electronically to Blue Shield. Blue Shield has contracted with several vendors for providers to submit claims at no cost. Electronic claims can also be submitted directly to Blue Shield via secure file transfer protocol (SFTP) using one of their own dedicated static IP addresses.

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

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.

Blue Shield pays all transaction fees for selected Electronic Data Interchange (EDI) vendors. Call the EDI Help Desk at (800) 480-1221 to obtain a connection or go to Provider Connection at www.blueshieldca.com/provider and click on the *Claims* tab for more information about the options listed above. You can also send an email to the EDI Department directly at EDI_BSC@blueshieldca.com.

Blue Shield, in accordance with HIPAA regulation, accepts electronic claims submitted in the ANSI format version 5010. Most electronic claim software packages follow the CMS 1500 format. The special billing guidelines and procedures instructions in Appendix 4-A apply to both the identified "block" on the CMS 1500 and the related "field" on the electronic record, unless otherwise indicated. Your electronic claims software may have additional specific requirements. Follow the system documentation provided by your software vendor.

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Claims Processing *(cont'd.)*

Encounter Submission

Providers are required to submit all encounter data to Blue Shield. Encounter data submissions may be made directly to Blue Shield or through a vendor. Regardless of the route of submission, providers may request the professional and facility encounter data specifications and procedures from Blue Shield using the contact information below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

Commercial and Medicare Encounter Data

EDI Operations: (800) 480-1221 – EDI questions only

For encounter processing questions, call the Customer Service number on back of the member's card.

EDI Clearinghouse Vendors

A list of approved Clearinghouse Vendors can be found on Provider Connection at www.blueshieldca.com/provider. Click on *Claims, Manage Electronic Transactions*, then *Enroll in Electronic Data Interchange*. You may also contact the EDI Help Desk at (800) 480-1221.

Paper Claim Forms (Using the CMS 1500 Claim Form)

All Blue Shield-contracted providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. As required by AB1455, electronically submitted claims will be acknowledged within 2 days and paper claims will be acknowledged within 15 days.

When paper claims forms are used with medical records attached, we require accurately completed CMS 1500 (or successor) forms to process claims quickly and efficiently. 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 that:

- 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, and ICD-10-PCS codes are sufficient. For drug codes, the CPT and NDC are required for consideration of payment.
- No white correction fluid is used
- Data is not touching box edges
- No special characters are used (e.g., dollar signs, punctuation marks, parentheses)

Claims Processing *(cont'd.)*

Provider Identification

Correct and complete provider identification on the billing provider, as well as on the rendering provider, is crucial to timely claims processing. Claims that do not identify the rendering provider may not be accepted or may possibly be denied payment and require resubmission with this information. For ancillary claims (independent clinical labs, DME/HME, and specialty pharmacy), the referring/ordering physician NPI is required in block 17B.

Refer to the CMS 1500 general instructions in Appendix 4 for information on provider identification, as well as to Appendix 4-A Special Billing Guidelines and Procedures for required rendering provider information in Block 24J and Block 33 of the claim form.

Providers Without a Blue Shield Contract

If you are a non-contracted provider, you must indicate your taxonomy code in the top box of 24J and your NPI in the lower block of the CMS 1500 when billing for services. If you do not have an NPI number, enter your California State License or Certificate number in Block 24J of the CMS 1500 when billing for services. Do not use the taxonomy or NPI of the supervising physician.

Note: Hospitals that act as the billing agent for hospital-based physicians (emergency room physicians, clinic physicians, anesthesiologists, radiologists, pathologists, etc.) and allied health professionals must obtain a separate nine-digit Blue Shield NPI for both group and individual providers to bill for these services.

Claims for these services must be submitted on a CMS 1500 claim form or transmitted electronically and must include not only the billing agent NPI but also the NPI of the provider who performs the service.

If you have questions regarding the provider identification process, please call Provider Information & Enrollment at (800) 258-3091.

Section 4: Billing

Claims Processing *(cont'd.)*

Filing “Clean” Claims

“Clean” claims are claims that have been completed correctly with all the necessary information to make a benefit coverage decision and identify the rendering provider. Filing “clean” claims allows Blue Shield to pay them quickly and accurately.

Providers should follow the most recently updated Current Procedural Terminology (CPT) coding guidelines (published annually by the American Medical Association), National Drug Code (NDC) for drugs as well as the HCFA Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, and coding guidelines published annually by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield removes deleted HCPCS and CPT codes from its claims payment system. To ensure timely payment, providers are encouraged to only submit currently valid and recognized CPT and HCPCS codes. For drug codes, the CPT and NDC are required for consideration of payment.

Encounters “Splitting” to Payable Injectable Claims

Claim payment is automated to process injectable claims that are exceptions to capitation and to reimburse the IPA/medical group directly. Claims for qualifying immunizations and injectable services that are payable exceptions to the capitated lines of service(s) submitted electronically will be split off from the encounter and processed accordingly.

Instructions for Claim Form Fields Requiring Special Attention

Some claim form fields cause the most common claims processing problems/denials and payment delays because of incomplete or invalid information. Please refer to Appendix 4-A Special Billing Guidelines and Procedures for instructions on completing claim form fields requiring special attention.

Timeliness Requirement

When you provide covered services to a Blue Shield member, you must submit your claims to Blue Shield within 12 months of the date of service(s) unless otherwise stated by contract. At Blue Shield's discretion, claims submitted after 12 months, without an accompanying explanation of reasons for the delay, may be denied. Subscribers are not responsible for charges denied for late filing.

Claims Processing *(cont'd.)*

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.

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 secondary submission. 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 Section 4.4, Paper Submission for more detail.

Instructions for Medicare 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~

Call the EDI Help Desk at (800) 480-1221 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.

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Claims Review Monitoring Program

Prepayment Claim Review

Blue Shield providers are expected to adhere to the highest standard of integrity in their billing practices. Blue Shield is committed to high quality, cost-effective care and monitors the coding and billing patterns of health care providers. Our monitoring program is designed to detect billing irregularities, including “unbundling” of services, incorrect modifier usage, and procedure coding inconsistent with current AMA and CMS guidelines.

Blue Shield strives to make its clinical payment and health plan specific policies transparent to providers. We have implemented claims editing software systems that are primarily based on industry standard correct coding rules, in order to pay professional providers accurately, consistently, and in a standardized manner.

Retrospective Review

Blue Shield’s Medical Care Solutions provides accurate and timely retrospective review of complex professional and institutional claims to determine medical necessity, utilization, and appropriateness of treatment. Providers may receive requests for medical records to augment the retrospective review process. Retrospective claims are reviewed per the contract language.

Provider on Review

Providers who consistently demonstrate questionable billing patterns may be placed on prepayment claims review and may be required to submit appropriate medical records for medical review *before* Blue Shield will pay claims.

The following are some examples of common billing irregularities that may result in prepayment review:

- Billing CPT codes at higher levels than supported by medical records (e.g., upcoding)
- Failure to include NDC and CPT for drugs
- Repeated itemized billing of paneled laboratory tests or unbundling services
- Falsifying medical/billing records
- Misrepresentation of providers of service
- Billing "consultations" for visits that are clearly patient-initiated
- Billing for services that aren't documented as having been performed in the medical record

Note: The above situations fall under our administrative compliance program and/or our Special Investigations Unit. Situations in which Blue Shield has identified aberrant billing pattern by a provider who does not follow Blue Shield’s recommendations for corrective action may result in a referral to the Provider Compliance Review Committee for further action up to and including administrative termination.

Provider Payment

Blue Shield Provider Allowances

“Blue Shield Provider Allowances” is the term used to describe the compensation schedules for providers who render medical, surgical, or other services to Blue Shield members. Providers are contractually obligated to accept the current Blue Shield Provider Allowances, including the member’s applicable copayment, as payment in full.

Blue Shield Provider Allowances compensate physicians and other healthcare professionals appropriately for medical services they render by capturing actual time, skill, training, and costs associated with providing the service. Blue Shield Provider Allowances are reviewed annually, apart from drug and immunization allowances which are reviewed quarterly, as new CPT-4 and HCPCS Level II Codes are added or existing codes change, per the American Medical Association. For drug codes, the CPT and NDC are required for compensation.

Blue Shield uses a variety of methodologies and factors when determining physician and other healthcare professional allowances to closely align payments with actual resources used by providers in rendering professional services. Reimbursement rates vary by region, of which Blue Shield has 24. Blue Shield also considers facility-based pricing for some procedures when establishing allowances.

Except for Blue Shield Provider Allowances for drugs and immunizations, Blue Shield will give providers at least 45 working days’ notice of changes to the Blue Shield Provider Allowances. Blue Shield Provider Allowances for drugs and immunizations reimbursed using Average Sales Price (ASP) or Average Wholesale Price (AWP) methodologies are reviewed quarterly and adjustments may be made without notification. NDC is required for payment consideration. Providers may terminate their participation with Blue Shield if they do not accept any changes to Blue Shield Provider Allowances.

Providers may obtain CPT code-specific allowances from Blue Shield in one of the following ways:

- Logging onto Provider Connection at www.blueshieldca.com/provider and navigating to the *Professional Fee Schedule* link under the *Claims* tab. Tier A and Tier B allowances are available. Tier A are professional fees provided in an office setting while Tier B are professional services provided in a facility setting.
- Calling Blue Shield Provider Information & Enrollment at (800) 258-3091

EOBs will also clearly state the Blue Shield Provider Allowance in effect on the date of service for each billed code.

A summary of Blue Shield Provider Allowances is provided below. Please also refer to the Blue Shield Payment Processing Logic document in Appendix 4-G which provides an overview of common Blue Shield claims adjudication processes. Blue Shield’s Payment Policies are available on Provider Connection at www.blueshieldca.com/provider under the *Claims* tab; Medical Policies are found on Provider Connection under the *Authorizations* tab.

Section 4: Billing

Provider Payment *(cont'd.)*

Blue Shield Provider Allowances *(cont'd.)*

Summary of Blue Shield Provider Allowances

- The majority of J Code allowances are determined using an Average Sales Price (ASP) plus reimbursement methodology, which promotes the use of value-based, cost-effective therapies by paying a greater percentage above ASP for generic and multi-source therapies as compared to single-source branded therapies. Allowances are reviewed quarterly using drug pricing data submitted to CMS by drug manufacturers and may be adjusted without notification to reflect changes in ASP. This reimbursement approach provides a reasonable margin over the acquisition cost for the drugs. Allowances for drugs without a published ASP, or billed using an “unclassified” HCPCS Code (such as J3490 or J9999), will be based on an Average Wholesale Price (AWP) less methodology, which are also reviewed quarterly.
- Immunization allowances are AWP-based.
- For drugs, CPT and NDC are required for payment regardless of reimbursement methodology.
- Anesthesia allowances are determined using the American Society of Anesthesiologists (ASA) codes utilizing coefficients tied to a geographic locality. For obstetric anesthesia, Blue Shield follows ASA methodology, which allows the base units, plus time units plus modifier units. However, reimbursement is subject to a cap of 23 total units.
- The following services are reimbursed on a statewide fee schedule:
 - Behavioral Health services (benefits may be administered through a specialty carve-out network).
 - DME, including orthotics and prosthetics.
 - Home health and home infusion services.
 - Selected maternity codes.

Note: The summary of Blue Shield provider allowances is subject to change upon proper notification.

Electronic Remittance Advice (ERA)

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 www.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 www.blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or by contacting the EDI Department at (800) 480-1221.

An ERA or EOP is also issued if a claim is denied for any reason, or if additional information is needed from the provider. A denial letter is sent when services to a Medicare member are denied.

ERAs or EOPs may be generated by other payors. For example, payments for services rendered to some national account subscribers may not be issued by Blue Shield. Payment for provider services that are covered under your Blue Shield contract are based on our allowances.

Tools at Provider Connection at www.blueshieldca.com/provider allow registered billing providers to execute their claims payment or processing status (updated nightly), execute multiple claims payment status inquiries (up to 10 members at once), and generate claims reports. The EOP information displayed on the claims details section of the website is the same information as the printed EOB. Providers can download a copy of the EOP from Provider Connection.

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.

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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 provider 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 provider 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:

1. Notify Blue Shield and the provider 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; and
2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;
3. Agree, in writing, to reimburse Blue Shield for benefits paid from any recovery received from the third party;
4. 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,
5. Respond to information requests regarding the claim against the third party, and notify Blue Shield and the provider 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.

Coordination of Benefits

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:
 - The group health plan of the custodial parent.
 - The group health plan of the spouse of the custodial parent.
 - 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

Coordination of Benefits *(cont'd.)*

When Blue Shield is the Primary Plan

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

Upon request, the provider 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 provider covers a service that would otherwise be the primary group health plan's liability, the provider 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*
- Coordination of Benefit Handbook, Thompson Publishing Group: www.thompson.com

Note: for information on determining the order of payment when the patient is also covered by Medicare, refer to Limitations for Duplicate Coverage - Medicare in this section.

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 professional providers 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, provider correspondence and inquiries.

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Mail hard-copy BlueCard claims that require medical records to:

Blue Shield of California
BlueCard Program
P. O. Box 1505
Red Bluff, CA 96080-1505

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 www.blueshieldca.com/bluecard.

Limitations for Duplicate Coverage (Commercial)

Veterans Administration (VA)

If the member is a qualified veteran who is not on active duty, 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). 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.

Section 4: Billing

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

Department of Defense (DOD), TRICARE/CHAMPVA

Blue Shield is always the primary payor for covered services, even if provided for conditions related to military service, delivered at a Department of Defense (DOD) facility when the member is a qualified veteran who is not on active duty. 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.

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 Payer 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.

Special Billing Situations

Ancillary Claims Filing Requirements

Health care providers should file claims for their Blue Cross and/or Blue Shield patients to the local Blue Plan, as traditionally defined. However, there are a few circumstances in which claims filing directions will differ, based on the type of provider and service. For these circumstances, the local Blue Plan is identified differently.

For ancillary services, the local Blue Plan is defined as follows:

- **Independent Clinical Labs:** All claims for clinical laboratory services provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area where the specimen was drawn, regardless of where the specimen is analyzed.
- **Durable/Home Medical Equipment (DME) and Supplies:** All claims for DME provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area to which the DME is shipped, or in which it is purchased at a retail store.
- **Specialty Pharmacy:** All claims for specialty pharmacy services provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area where the ordering physician is located.

Note: Claims will be paid based on the provider's participation status with the local Plan as defined above, regardless of the provider's status with Blue Shield.

For more detailed information about the Ancillary Claims Filing Requirements for independent clinical labs, DME providers and specialty pharmacy providers, log onto www.blueshieldca.com/provider, click on the *Ancillary Providers* link under *Helpful Resources*, and then select the *Ancillary Claims Filing Requirements box* at the bottom of the web page.

For questions about filing ancillary claims under these requirements, call our BlueCard Claims Unit at (800) 622-0632.

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.

CRNA Billing

All CRNA claims must be billed with one of the Modifiers QS, QX or QZ, noted in the payment policy for "Anesthesia Services" located on Provider Connection, or the claim will be denied.

Section 4: Billing

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 care 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

Hospice claims should be submitted to Blue Shield by the hospice provider. Services must be billed on the 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:

- 0651 – Routine home care
- 0652 – Continuous home care
- 0655 – Inpatient respite care
- 0656 – General inpatient care
- 0657 – 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.

Consultation Visit Prior to Hospice Care

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

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

Special Billing Situations *(cont'd.)*

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 MCO 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. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

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. The HMO may directly bill for attending physician services, as listed above, to Medicare carriers in keeping with existing processes.

Medicare physicians may also bill such service directly to carriers as long as all current requirements for billing for hospice beneficiaries are met. Revised requirements for such billing were set forth in Transmittal 1728, Change Request 1910 of the Medicare Carriers Manual (MCM), Part 3 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.

Section 4: Billing

Special Billing Situations *(cont'd.)*

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

Billing of Covered Services *(cont'd.)*

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.

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 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 with the specific codes designated by Medicare (e.g., GW modifiers) and 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 that 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 Modifier GW and should denote that the treatment is not for the CHF condition, which is coded as covered under hospice.

Resources: *Medicare Hospice Manual*; Chapter 11 *Medicare Managed Care 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.

Special Billing Situations *(cont'd.)*

Major Organ Transplant (MOT) Billing

Payment for professional services for major organ transplants (bone marrow, stem cell, liver, lung, heart, heart/lung, kidney/pancreas, small bowel with liver, and multi-organ) will be paid by the in-network facility where the transplant was performed. Blue Shield has contracted with selected transplant facilities to pay a global case rate for this procedure. If the physician receives the following denial message from Blue Shield: *“Payment for these services are included in the global case rate paid to the facility,”* along with an Explanation of Benefits (EOB), payment for the professional service can be secured by submitting a copy of the claim and the EOB to the facility where the transplant was performed.

Questions about the global transplant case period may be directed to Provider Information & Enrollment at (800) 258-3091.

Office-Administered Injectable Medications

Pharmaceutical supplies, including but not limited to, the drugs required to provide members with office-administered injectables are the responsibility of the physician and will be reimbursed by Blue Shield according to established allowed amounts for the services rendered to Blue Shield members. In addition, select medications are available for Drop Ship from a Blue Shield preferred pharmacy. Drop Ship is a voluntary program, in addition to the buy-and-bill method, for providers to procure office administered medications. The drop ship option will only be available for select drugs and does NOT replace buy and bill. Under this program, physician offices order medications from a Blue Shield preferred pharmacy on an individual patient basis. The pharmacy delivers the drug to the physician office and bills Blue Shield for the cost of the drug. After the member receives treatment, the physician only bills Blue Shield for the administration costs. Physician offices will continue to be required to procure medications through the buy-and-bill method for drugs not available through the Drop Ship program. A list of the Drop Ship medications and preferred pharmacies can be found on Provider Connection at www.blueshieldca.com/provider. For questions regarding billing of office administered injectable medications, please call Provider Information & Enrollment at (800) 258-3091.

Additionally, Blue Shield Physician members are required to:

- Provide Covered Services they are licensed to provide and seek payment only from Blue Shield for those services.
- Provide all necessary supplies and materials required to administer injectables in the office. Physicians should not instruct Blue Shield members to obtain injectable drugs from the pharmacy prior to an office visit for the purposes of administering such drug(s) in the office.
- *Note:* Instructing members to obtain drugs prior to an office visit is a violation of the Independent Physician Agreement and the Knox-Keene Act, which could result in contract termination.
- Submit the appropriate billing for services rendered to Blue Shield and collect only the authorized copayment from the member.

A complete list of infused and office administered medications, which include appropriate procedure codes for billing and their authorization requirements for coverage in the medical benefit, can be found on Provider Connection at www.blueshieldca.com/provider under *Authorizations, Clinical Policies and Guidelines, Medication Policy*, and then *Medication Policy List*.

Section 4: Billing

Special Billing Situations *(cont'd.)*

Office-Based Ambulatory Procedures

Office-based ambulatory procedures should be performed in a physician office setting, unless it is medically necessary that they be performed in a facility setting on either an outpatient or inpatient basis.

The list of office-based ambulatory procedures is provided in Appendix 4-H List of Office-Based Ambulatory Procedures.

Claim Inquiries and Corrected Claims

Blue Shield utilizes Optical Character Recognition (OCR), which allows paper claims to be scanned and data interpreted with minimal data entry. It is important that all claims have no comments, writings, or descriptions other than those outlined in the processes below.

Resubmissions or Corrected Claims

Resubmission

If a claim needs to be re-submitted 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 www.blueshieldca.com/provider.
- Transmit a 276 electronic claim status transaction.
- If the original claim was not received, re-submit the claim electronically.

Corrected Claims

Corrected claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. 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, re-submit the corrected claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on the adjusted claim:

- 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).

Claim Inquiries and Corrected Claims *(cont'd.)*

Corrected Claims *(cont'd.)*

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

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

- Corrected billings 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).

Overpayments

Blue Shield's process and procedures for notification of overpayments and offset shall be in accordance with the regulations at 28 California Code of Regulations Section 1300.71. In the event you disagree or contest Blue Shield's notice, you should notify us, in writing, within thirty (30) working days of receipt. Please refer to Provider Appeals and Dispute Resolution, within this section, for additional information.

If you do not contest or object a notice of overpayment, you should reimburse Blue Shield within 30 working days of receipt. In the event you fail to reimburse Blue Shield, you authorize Blue Shield to offset such uncontested overpayments from your current claim submissions.

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 www.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

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, 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, or disputing a request for reimbursement of an overpayment of a claim; and a written notice to Blue Shield, submitted to the designated provider appeal address, disputing 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, 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, that are individually numbered using the Blue Shield assigned claim number to identify each claim contained in the bundled appeal; or a written notice, submitted to the designated provider appeal address, identifying 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).

Receipt Date

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

Appeal Determination Date

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

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

Definitions *(cont'd.)*

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.

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

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

Email: 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

Email: plans-providers@dmhc.ca.gov

Unfair Payment Patterns

Unjust payment patterns include:

- Imposing a claims 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 payors 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 9% 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

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 www.blueshieldca.com/provider

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 www.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.

Section 4: Billing

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

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

Online Access

The Provider Appeal Resolution Process is available to registered users on Provider Connection at www.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.

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.

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

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

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 an Initial Appeal

Initial Appeals must be submitted in writing to the following address:

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

Initial appeals regarding facility contract exception(s) must be submitted in writing 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

Required Information/Appeal

An appeal must be submitted in writing and 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

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.

Section 4: Billing

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

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

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.

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.

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

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

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 paper appeal within 15 working days of the receipt of the written appeal.

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

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 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 written request to the following address:

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

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

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.

Capitated Entity (IPA/MG/Capitated Hospital) Appeal Resolution Requirements

IPA/Medical Group Responsibilities

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

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

Blue Shield Contracts

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

The IPA/medical group'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.

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 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.

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'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 requests to Blue Shield within 60 working days from the date they received the IPA/medical group determination.

Section 4: Billing

Provider Appeals of Medicare Advantage Claims

Contracted

Contracted 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 – mailing address and phone number
- Blue Shield's Internal Control Number (ICN)/Claim number, when applicable
- 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).

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

Contracted *(cont'd.)*

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.

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
- 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 days of receipt of the provider request for redetermination, review the appeal and respond to the physician or provider using the Provider Appeals 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.

Section 4: Billing

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

Non-Contracted

CMS requires Medicare Advantage Organizations (MAOs) 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.

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO and/or delegated entity) 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 and/or delegated entity'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 a MAO Plan and/or delegated entity. The time frame for disputing a reimbursement issue to the MAO Plan and/or delegated entity is 125 days from the initial determination date.

The provider payment dispute process cannot be used to challenge denials by organizations that result in zero payment being made to the non-contracted provider. The payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process.

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 14 calendar days from the date of request, Blue Shield will conduct a review based on what is available.

Blue Shield will resolve the dispute within 30 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 and/or delegated entity makes its Payment Review Determination (PRD) decision, if a deemed or non-contracted provider or supplier still disagrees with the pricing decision of a MAO Plan and/or delegated entity, a second level review may be requested in writing within 180 days of written notice from the MAO Plan and/or delegated entity of its Payment Review Determination.

To appeal the provider organization and/or delegated entity'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