Ancillary claims filing requirements: DME claims

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agenda

Objectives for this presentation:

• Inform you of current and future Blue Shield of California’s (Blue Shield) claims filing requirements for Durable Medical Equipment (DME) companies

• Review DME claims filing work-flow/process

• Review Blue Shield’s DME contract policy

• Answer your questions and provide Blue Shield contact information
brief overview

• Blue Shield requires DME providers to submit claims to Blue Plans based on the location to which the equipment was shipped, or where it was commercially purchased.

• Blue Shield is required to review all DME claims received to identify that the claim was sent to the correct Blue Plan by checking the location to which the equipment was shipped or purchased at a retail store.

• We follow these guidelines developed by the Blue Cross Blue Shield Association (BCBSA) for all local Blue Plans to ensure consistent processing of the DME claims for all Blue Plans.

• Blue Shield has developed both provider and member education materials to inform providers and members prior to implementing these systematic and process changes regarding the handling of DME claims.
requirements for accurate and complete submissions

- Blue Shield should only receive claims which pertain to equipment that has been shipped to or commercially purchased at a location within our service area.

- The DME claim form identifies the member’s permanent address, which may differ from the address to which the equipment was shipped or where it was purchased.

- If no “shipped to” or “purchased at” address is submitted on the claim, the patient’s home address on the claim form will be used to determine the local Blue Plan service area.
requirements for accurate and complete submissions, cont’d.

• DME providers must populate all required data fields and include all required information in order for Blue Shield to view it as a “clean claim.”

• For example, you must:
  
  ✓ Complete referring provider information and all other required information
  
  ✓ Submit the claim on the correct form

• Beginning October 14, 2012, if the requirements are not met, Blue Shield will return the claim to the DME provider with a request for the missing information.
processing of “clean claims”

Once Blue Shield receives a “clean claim” (containing all required fields/information), we will take the following steps:

1. Validate the “shipped to,” or “purchased at,” or patient home address information as being within our service area.

2. Process the claim if the DME provider is within our service area or has provided equipment that was shipped to a member within our service area.

3. If the DME “shipped-to” address is outside of Blue Shield’s service area and it has been determined that the equipment was not sent to a member in our service area, we will return the claim to the submitting DME provider with instructions to file it with the Blue Plan to whose service area the equipment was shipped.

Again, beginning October 14, 2012, if these requirements have not been met, Blue Shield will return the claim to the DME provider with a request for the missing information.
these filing requirements do not apply to FEP ancillary claims

• These claim filing instructions do not apply to Blue Cross Blue Shield Federal Employee Program (FEP) Benefits.

• Submit FEP members’ DME claims to Blue Shield of California either electronically or to P.O. Box 272510, Chico, CA 95927-2510.
completing required fields on the DME claim

Electronic Claims
- Loop 2010CA on the 837 Professional Electronic Submission.
- Loop 2420E (line level) on the 837 Professional Electronic Submission.
- Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions.

Service Facility Location Information:
- Loop 2310C (claim level) on the 837 Professional Electronic Submission.

Paper Claims:
- Field 5 on CMS 1500 Health Insurance Claim Form (Patient’s Address) or
- Field 17 on CMS 1500 Health Insurance Claim Form (Ordering Providers) or
- Field 24B on the CMS 1500 Health Insurance Claim Form (Place of Service) or
- Field 32 on CMS 1500 Health Insurance Form or (Provider Address)
Blue Shield’s DME Provider Contract Policy

- A Blue Plan’s decision to contract with an out-of-service area DME provider is voluntary.

- BCBSA does not facilitate provider contracting among multiple plans; providers must independently contact Blue Plans if they desire to contract with them directly.

- Blue Shield’s current policy permits contracting with DME providers located out of our service area. All DME providers contracted with Blue Shield must meet the following general requirements:
  - Maintain current licensing
  - Complete Blue Shield’s provider credentialing application
  - Comply with Blue Shield’s medical policy
  - Execute Blue Shield’s Alternate Care Services Agreement
  - Agree to Blue Shield’s allowances/reimbursement terms as payment in full
contact blue shield for assistance

**Electronic claims:**
EDI_BSC@blueshieldca.com  
EDI phone: (800) 480-1221

**Ancillary network/contracting:**
Ian Bautista, Network Manager, Ancillary & Specialty Networks  
E-mail: ian.bautista@blueshieldca.com  
Phone: (818) 228-2539

**Claims:**
Blue Shield’s BlueCard® Claims Unit  
Phone: (800) 622-0632

**BlueCard Benefits Hotline:**
Phone: (800) 676-2583 or blueshieldca.com/provider (click on “Eligibility & Benefits” and select “Verify Eligibility”)

**General BlueCard questions or education:**
Barbara Keryluk, Senior BlueCard Consultant  
E-mail: barbara.keryluk@blueshieldca.com  
Phone: (714) 603-7887
frequently asked questions
Q: What if a code a provider is using to bill, e.g., G0429, is not categorized by Blue Shield as DME, but another Blue Plan does categorize it as DME?

A: Sometimes Blue Plans will disagree on whether a service is considered to be ancillary. Such cases are handled as exceptions on an inquiry basis. We will work with other plans to resolve these exceptions.
Q: Should Loop 2310C on 837P or Block 32 on the CMS 1500 form list the provider address only, or a “ship to” address if it is different from the patient’s permanent address?

A: If the claim shows the service is provided at home, we generally look to the patient’s address. But if it’s being shipped to a place other than their home address, it would be appropriate to list the “shipped to” address in Block 32 or Loop 2310C.
Q: Do you accept electronic claims from non-participating and/or out of state providers? If so, how can I get set up to submit and access my claims information electronically?

A: Yes, we will accept electronic claims from non-participating and out of state providers. Contact Provider Services at (800) 258-3091 to obtain a Provider Identification Number or you can use a clearing house that is among those already approved by Blue Shield.

To check the status of your electronic claim, you can register for a login to our provider portal if you have a provider ID number already in our system, or you can send a real time 276/277 transaction through one of our existing trading partners.
Q: Why can't the providers bill their local plan?

A: The ancillary claims filing rules require DME/HME claims be billed to the plan or state where the ordering physician is located. The rules have been established to protect the service areas and provider networks of the participating health plans.
Q: Which Blue Plan's medical policy is used to process a DME/HME claim for a Blue Plan member?

A: The medical policy of the member's Blue Plan will be used.
Q: How do Plans handle a scenario when a local provider (AZ) goes to the Plan (AZ) to request a claim status for a claim filed to another Plan (CA)?

A: Providers must be educated on where to send their inquiries for ancillary claims which should correlate with where a claim is filed as is consistent with all claim types. However, Plans are not required to reject non-claim transactions if a provider inadvertently sends a non-claim transaction to the Blue Plan where the provider is physically located.
Q: If providers submit Medicare primary claims directly to Blue Shield, how does Blue Shield process the claim?

A: If the ancillary services were rendered in California, Blue Shield processes the claim as the local plan. If the ancillary services were rendered in a different plan's service area, Blue Shield will reject the claim back to the provider that submitted the claim and instruct them to submit the claim to the correct local plan.
Q: Do these rules apply when Blue Shield is not the primary plan?

A: For claims where Blue Shield is secondary or tertiary to another commercial plan, ancillary rules do apply. For claims where Blue Shield is tertiary and Medicare and another commercial plan are processing before Blue Shield, we will apply these rules.
Q: Do these requirements apply to Blue Shield 65 PlusSM HMO members (i.e. Blue Shield's Medicare Advantage Plans)?

A: Yes, these requirements apply to Medicare Advantage plans in the same way as other plans. If Blue Shield is the local plan, then we would continue to process the claims. If we have determined that Blue Shield is not the local plan – the claims would be denied to the provider advising them to bill the correct plan. For HMO members, care delivery rules still apply.
Q: Do ancillary rules apply to Medicare Crossover claims (ie claims that cross over to Blue Shield through Blue Shield's Medicare vendor)?

A: Yes, at a future date to be communicated by Blue Shield. This will not be part of the October 14 implementation.
Q: Does payment always come from the member’s plan?

A: Member benefits are held by the member's plan; however, payment is typically sent by the local plan as defined by ancillary rules.
Q: If our claim is processed out-of-state by a payer with whom we are not contracted, will we be reimbursed at the same contract rates we have with Blue Shield?

A: If you are not contracted with the out-of-state payer that processes your claim, it will be processed as an out-of-network claim by the payer.
Q: If a claim is sent back to the provider from the Blue Plan because it was sent to them in error, will that Blue Plan indicate which other Blue Plan is the correct one?

A: If a claim is rejected for that reason, it will be returned to the provider with instructions to re-file it with the correct local Blue Plan as defined by the requirements. The rejecting Blue Plan is not required to identify the correct local Blue Plan when it returns the claim.
Q: What impact will the new claims filing requirements have on current out-of-state ancillary contracts, if any?

A: There is no impact or change to existing out-of-state contracts. Providers may need to pursue new remote contracts with the other Blue plans where claims are submitted.
Q: How do providers from other states pursue a contract with Blue Shield?

A: Contact Provider Services at (800) 258-3091
Q: In states where there is more than one Blue Plan provider, does a DME/HME provider have to be contracted with both Blue Plans in order for the claims to be processed as in-network?

A: You need to submit your claim to the correct local plan as defined by these guidelines. If you have a contract with the local plan, your claim will be paid as participating. If you do not have a contract with the local plan, your claim will be paid as non-par.
Q: If we are contracted with Blue Shield but file DME claims for Anthem Blue Cross of California to Blue Shield will you process them as participating providers even though we don't have a contract with Anthem Blue Cross?

A: We do not accept claims on behalf of Anthem Blue Cross, nor do we re-route claims to them. If you submit your claim to Blue Shield as a participating provider, we will process your claim and pay it as such; if you submit the claim to Anthem, they can choose to process your claim, but since you have no contract with them they would process it as a non-participating provider.
Q: Are these guidelines applicable to claims handled by third party administrators / funds

A: Yes, these rules apply to claims handled by TPAs and funds.
appendix
DME claim filing scenarios
DME claim for blue shield of california member

1. Blue Shield of California member orders wheelchair online from provider in Iowa.

2. Blue Shield of California has a contract with the DME provider in Iowa.

3. DME provider in Iowa ships the wheelchair to the BSCA member in California.

4. DME provider in Iowa submits claim for wheelchair to Blue Shield of California

A DME claim should be sent to the Blue Plan in the service area to which equipment is shipped or where it was purchased at a retail store.

Blue Shield of California reimburses the participating DME provider in Iowa because the wheelchair was shipped to California.
Example of misrouted DME claim for blue shield of California member living in Texas

1. A Blue Shield of California member who resides in Texas is visiting with family in Arizona.
While in Arizona, the member orders DME online from provider in Arizona.

2. The Arizona DME provider has a contract with BCBS Texas.
The DME is shipped to the BSCA member’s residence in Texas.

3. Even though the Arizona DME provider has a contract with BCBS Texas, the provider incorrectly bills Blue Shield of California for the DME.

4. BSCA rejects the DME claim and returns it to the Arizona DME provider with DF Code 1069. The Arizona DME provider must bill BCBS Texas because the DME was shipped to Texas.
appendix:
required data for DME claims
Generally, DME provider should file claims for Blue Plan patients with the local Blue Plan, i.e., the Plan service area to which the equipment was shipped or where it was purchased. These claim filing instructions do not apply to Blue Cross Blue Shield Federal Employee Program (FEP) Benefits. Submit FEP members’ DME claims to Blue Shield of California either electronically or to P.O. Box 272510, Chico, CA 95927-2510.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>How to file (required fields)</th>
<th>Where to file</th>
<th>Example</th>
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| Durable Medical Equipment and Supplies (DME)    | **Electronic Claims**  
  - Loop 2010CA on the 837 Professional Electronic Submission.  
  - Loop 242OE (line level) on the 837 Professional Electronic Submission.  
  - Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions.  
  **Service Facility Location Information:**  
  - Loop 2310C (claim level) on the 837 Professional Electronic Submission.  
  **Paper Claims:**  
  - Field 5 on CMS 1500 Health Insurance Claim Form (Patient’s Address) or  
  - Field 17 on CMS 1500 Health Insurance Claim Form (Ordering Providers) or  
  - Field 24B on the CMS 1500 Health Insurance Claim Form (Place of Service) or  
  - Field 32 on CMS 1500 Health Insurance Form or (Provider Address) | File the claim to the Plan in whose state the equipment was shipped to or purchased in a retail store.                                                                                                                                 | 1. Wheelchair is purchased at a retail store in California.  
   **File to:** Blue Shield of California  
  2. Wheelchair is purchased on the internet from an online retail supplier in California and shipped to Blue Plan member residing in Arizona.  
   **File to:** Blue Cross Blue Shield of Arizona |