Ancillary Claims Filing Requirements
Frequently Asked Questions

The following questions were received in response to our provider webinars presented by Blue Shield of California’s network management teams.

Clinical Lab

Q: Will out-of-state independent clinical laboratories that are contracted with Blue Shield of California receive in-network reimbursement for a Blue Shield of California member’s claim?
A: Yes, regardless of your laboratory location, if the specimen was drawn in California and laboratory is contracted with Blue Shield of California, you will receive payment as a participating provider for such a claim.

Q: If the lab where the specimen was drawn is located in Oregon, but the ordering physician is located in California, which plan is the local plan?
A: According to ancillary rules, the location of the ordering physician is used to determine where the specimen was drawn. Please use the location of the ordering physician in Loop 2310A on the 837P form or box 17 on the CMS 1500 form.

Q: On paper claims, Block 32 for HIPAA states, “Services where testing is performed”. How should we complete this differently for Blue Shield to adhere to the requirements?
A: Blue Shield of California follows the HIPAA 5010 IG that states: 2310C is required when the location of the health care service is different than that carried in Loop ID- 2010AA billing provider.

Q: Are the terms “referring provider” and “ordering provider” interchangeable in the clinical laboratory policy? Are we required to find the member’s primary care physician who may have referred the patient to a specialist, when the specialist is the ordering provider?
A: In the context of this policy for clinical lab orders, the “referring provider” and “ordering provider” are interchangeable, and you are only required to identify the physician who ordered the lab work.
Q: Can you confirm what location to report in 2310c on the 837? Is it the location where the specimen was collected? What about the referring physician’s name, address, National Provider Identifier (NPI) if the specimen is drawn in the physician’s office?
A: The name, address, and NPI of the ordering physician should be entered in the designated blocks on the 837. This information is used to determine where the specimen was drawn.

Q: The Billing Provider can only put one Referring Physician's ID in box 17 of the 1500 Health Insurance Claim Form. How can the Billing Provider identify who ordered the test and who obtained the specimen in one box?
A: Billing Providers should be instructed to follow the National Uniform Claim Committee instructions regarding how information is populated on the 1500 Health Insurance Claim Form, box 17 - Name of Referring Provider or Other Source.

**Specialty Pharmacy**

Q: How does Blue Shield determine where the ordering physician on a specialty pharmacy claim is located for the purposes of disposition of the claim? Is it based on the NPI supplied?
A: The ordering physician information is supplied in Field 17 of the CMS form or Loop 2310A in the 837P. The NPI information does also indicate the correct local Blue Plan for the claim.

Q: Our claims are sent via Novologix. Are they aware of these changes and will they send to appropriate plan?
A: Novologix is aware of these ancillary claims filing requirements for specialty pharmacy claims, and they are currently enhancing their system specifically for BSC providers to flag the claim from a referring physician outside of California. Such a claim will contain a reject message saying the provider should re-submit the claim to the appropriate local Blue Plan. Novologix will not send the claim to the correct local plan.

Q: What if the local Blue Plan, under these requirements, defines benefits differently from Blue Shield (i.e., if specialty medication is handled through pharmacy and not medical benefits)-how would the specialty medication claim be processed?
A: If we (Blue Shield of California) receive a claim for a BlueCard member with benefits under an out-of-state Blue Plan, we will send it to that plan as a medical benefit. If the local Plan rejects it under medical benefits, you would be informed.
**Specialty Pharmacy (continued)**

Q: Do Blue Shield of California's specialty pharmacy benefits include both infusion and injectables?
A: Certain injectables apply under Blue Shield's medical benefits. Medical policy is available online for viewing at blueshieldca.com/provider. If you have further questions, please feel free to contact Blue Shield.

Q: Does BSC consider enteral/parenteral services to be DME or specialty pharmacy?
A: BSC considers the services specialty pharmacy and will determine the local plan based on the location of the ordering physician.

Q: Are all home infusion pharmacies considered specialty pharmacies?
A: Yes, BSC does consider all home infusion pharmacies to be specialty pharmacy.

Q: If a physician has moved to California but has not updated NPI information, do we use the information associated with the NPI or the actual service area in which they ordered the specialty medication?
A: If Blue Shield has the physician on file as a network provider, we will have their updated information. Claim forms also have a field for the ordering physician’s location.

**DME**

Q: What if a code we are using to bill, e.g., G0429, is not categorized by Blue Shield of California 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.
**DME (continued)**

Q: Do urological supplies (e.g., catheters, leg bags and ostomy supplies) fall under the DME category that would be subject to these requirements?
A: Generally, yes, Blue Shield does consider those supplies as DME. We determine if a claim is DME based on the provider's information on the claim.

Q: We are not in Blue Shield's network. Can we bill for oxygen for a Blue Shield member?
A: Yes, you can certainly bill for oxygen. However, if we are the local plan as defined by ancillary rules, be advised that we would adjudicate your claim as an out-of-network claim and therefore, not at the member's highest benefit level.

Q: Is there a way that the BlueCard tool at blueshieldca.com/provider can show the Blue Plan that should receive a DME claim, based on the alpha prefix?
A: The Claims Routing Tool at blueshieldca.com/provider does not apply to DME claims.

Q: I provide enteral/parenteral services. Do I use my specialty pharmacy or DME PIN on my claims?
A: Providers that can render both DME and enteral/parenteral services should bill DME services with their DME PIN; they should bill enteral/parenteral services with their specialty pharmacy PIN.

Q: For DME claims, is the ordering provider NPI required to determine the Local Plan?
A: No. The ordering provider NPI is required on DME claims to support medical records requests.

**Authorization**

Q: When an out-of-state physician has prescribed specialty medication and the claim is sent to the out-of-state Blue Plan in whose service area that physician is located, which Blue Plan should we contact for authorization?
A: You need to check authorization with the Blue Plan that holds the member's benefits regardless of which Blue Plan is the local plan.
**Billing**

Q: Can out of state providers bill other plans electronically?
A: We are unable to answer questions about other Blue plans, however BSC is allowing out of state providers to bill to us electronically, regardless of contract status.

**Contracting**

Q: What impact will the new claims policy 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 BSC?
A: Contact provider services at 800-258-3091

Q: In states where there is more than one Blue Plan provider, do ancillary providers 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 of California but file clinical laboratory, specialty pharmacy or DME claims for Anthem Blue Cross of California to Blue Shield of California will you process them as participating provider 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 of California 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: Who receives payment for a claim when the ancillary provider is not contracted with Blue Shield of California? The patient or the provider?
A: Blue Shield's payment policy is to issue payment to our subscriber if BSC is the local plan and the claim is for our member.
Contracting (continued)

Q: Is your network closed to new clinical laboratories, specialty pharmacies or DME/HME providers?
A: No, Blue Shield of California is allowing out of state ancillary providers who meet our credentialing requirements and render services within our service area to join our network.

Q: Why are Blue Plans now allowed to contract with clinical labs, specialty pharmacies and DME providers outside of their service area, when they cannot generally contract with other types of providers outside of their service area according to Blue Cross Blue Shield guidelines?
A: BCBSA has made these exceptions in response to the current and changing structure of the laboratory, specialty pharmacy and DME industries to support productive business transactions with those industries.

Q: Is there a difference between "participating" providers and "preferred" providers?
A: The term "participating" refers to a provider's contract status: a provider is either "participating" (is contracted with Blue Shield) or "non-participating (is not contracted with Blue Shield). The term "preferred provider organization (PPO) provider" can only be used to describe a "participating" or "network" provider.

Q: Is Blue Shield of California's provider contracting policy the same as all other Blue Plans, or is your contracting policy unique to Blue Shield of California?
A: Each Blue Plan determines its own provider contracting policy, and we are only able to speak to Blue Shield of California's policy.

Q: In the event that we are not contracted with the Blue Plan in whose area the ordering physician is located, how would our claim be processed: in-network or out-of-network?
A: If you are not contracted with the local Blue Plan as defined by ancillary rules your claim would be processed as out-of-network.

Q: How long does it take to get contracted with Blue Shield of California once the correct forms are submitted? What would be the effective date of the contract?
A: Generally speaking, it takes about 30 days to fully execute a new contract with Blue Shield of California. The effective date is the date the appropriate executive at Blue Shield has approved and signed the contract. Copies of the executed contract are returned to the provider.
**Electronic Claims**

Q: Do you accept electronic claims from non-participating 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 of California.

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.

**Exclusions**

Q: Are any plan types other than FEP excluded from these requirements (e.g. Commercial HMO, Medicare Advantage HMO, Medicare Advantage PPO)?
A: The Medicare Advantage plans are included in this policy. FEP is the only exclusion at this time.

**Implementation**

Q: Currently, some Blue Plans have already implemented these requirements but others have not. How do we get these claims processed?
A: We can only speak to Blue Shield of California’s plans and timing for implementing these requirements. It is important to inquire with each Blue Plan to which you are sending claims as to their implementation timeline for the requirements.

Q: Can we start billing the home plan where the specimen was collected now? Or do we have to wait till 10/14/2012?
A: We can only speak to Blue Shield of California’s plans and timing; for claims we receive, we will begin using these policies on 10/14/12.
**Implementation (continued)**

Q: I tried to file a claim with the local plan as defined by the new rules but they indicated they do not work with out of state providers
A: The plan with which you filed your claim has likely not implemented these rules yet. As of 10/14 all plans will have implemented. We recommend you contact the plan where you filed the claim for guidance on how to proceed.

**Local Plan**

Q: Why can't the providers bill their local plan?
A: The ancillary claims filing rules require ancillary claims be billed to the plan or state where the specimen was drawn, equipment was shipped (or purchased on site) or 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 clinical laboratory, specialty pharmacy or DME 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: For out of state ancillary claims, which Plan should the providers call for prior insurance verification?
A: For prior insurance verification, call the number on the back of the patient's insurance ID card.

Q: Do you have a list of each Blue Plan and what service area they cover? How often do the service areas change?
A: We are unable to provide that information for other Blue Plans to you. We recommend that you check with each Blue Plan in which you are interested to verify their service area.
Local Plan (continued)

Q: Do providers need to complete any payer enrollment forms with other Blue Plans prior to submitting our claims to them directly?
A: We are unable to answer questions about other Blue Plans.

Q: Do these requirements apply to both Anthem Blue Cross in California and to Blue Shield of California?
A: We can only speak to Blue Shield of California's policy; please refer to each plan directly with questions about their policies.

Q: Does this policy replace BlueCard® for submitting claims? I've heard different answers, depending on the Blue Plan.
A: No, this policy does not replace BlueCard policy, which should be applied under the circumstances that require BlueCard filing of claims.

Q: If we are billing to the physician’s local plan, is there ever a point where that local plan will share risk with a medical group? What if we are non-contracted with that medical group, how will we get reimbursed?
A: The situation described does not impact billing process. These requirements for ancillary services should still be used.

Q: Some states have more than one Blue Plan. How do I know where I should send my claim?
A: Blue Shield of California is not able to provide guidance regarding other states' plans. Please direct those questions to the Blue Plan(s) in question.

Q: What happens if the local plan does not consider a provider as ancillary?
A: Sometimes Blue Plans will disagree on whether a service is considered to be ancillary. Such cases are handled individually, as needed. Please contact customer service at the member’s plan for assistance in resolving those claims issues.

Q: How do Plans locate the local claims filing address for other Plans?
A: The BlueCard Claims Processing Manual, available on BlueWeb, provides the address where providers in your state may file claims. Please refer to the Provider Administrative Billing Practices section of the BlueCard Claims Processing Manual.
**Medicare**

Q: If providers submit Medicare primary claims directly to BSC, how does BSC process the claim?  
A: If the ancillary services were rendered in California, BSC processes the claim as the local plan. If the ancillary services were rendered in a different plan's service area, BSC 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 BSC is not the primary plan?  
A: For claims where BSC is secondary or tertiary to another commercial plan, ancillary rules do apply. For claims where BSC is tertiary and Medicare and another commercial plan are processing before BSC, we will apply these rules.

Q: Do these requirements apply to Blue Shield 65 plus HMO members (i.e. BSC’s Medicare Advantage Plans)?  
A: Yes, these requirements apply to Medicare Advantage plans in the same way as other plans. If Blue Shield of California is the local plan, then we would continue to process the claims. If we have determined that BSC 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 (i.e. claims that crossover to BSC through BSC’s Medicare vendor)?  
A: Yes, at a future date to be communicated by BSC. This will not be part of the 10/14/12 implementation.

**Payment**

Q: Does payment always come from the home plan?  
A: Member benefits are held by the member's home 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.
Payment (continued)

Q: Where should I send claims if a state outside of California does not follow these ancillary claims filing requirements for independent clinical laboratories?
A: Each Plan is required to implement these rules by October 14, 2012.

Q: When the provider submits an ancillary claim to the Blue Plan in whose service area the ordering physician is located, does the payment still "follow" the member (is based on the member's home plan?)
A: Final payment is determined by the member's home plan. However, the payment itself is issued by the local plan.

Rejected Claims

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: Will all Blue Plans forward provider submitted claims sent to them in error to the correct Blue Plan? If so, for how long?
A: Although Blue Plans may implement these requirements at different times, once the Blue Plan is in compliance, it will return incorrectly submitted claims to the billing provider with instructions to submit the claim to the correct local Blue Plan, as defined by ancillary rules. Blue Shield will begin to return incorrectly submitted claims on October 14, 2012. Claims submitted by members will be rerouted to the correct local plan.

Q: Under these requirements, will the same denial code be used by all Blue Plans, nationally, if a claim is sent to the wrong Blue Plan?
A: It would not be the same code, because each plan is implementing these rules individually. Each Blue Plan, however, will be following the same requirements. Some claims sent via EDI will be rejected up front before they enter the claims system, so providers should watch their 277CA for rejection messages.
Third-Party Administrators

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.