MASSACHUSETTS

October 25, 2023

DOING BUSINESS WITH BLUE CROSS

A WEBINAR FOR BEHAVIORAL HEALTH PROVIDERS

AGENDA

- Introductions
- Mental Health Page on Provider Central
- Telehealth and CPT HCPCS Modifiers payment policies
- ConnectCenter
- Claim Status
- Replacement Claims
- Appeal Status
- Timely Filing
- Questions?

WELCOME

Steve

Provider Service Senior Manager

Chelsea

Provider Service Leader

Brooke

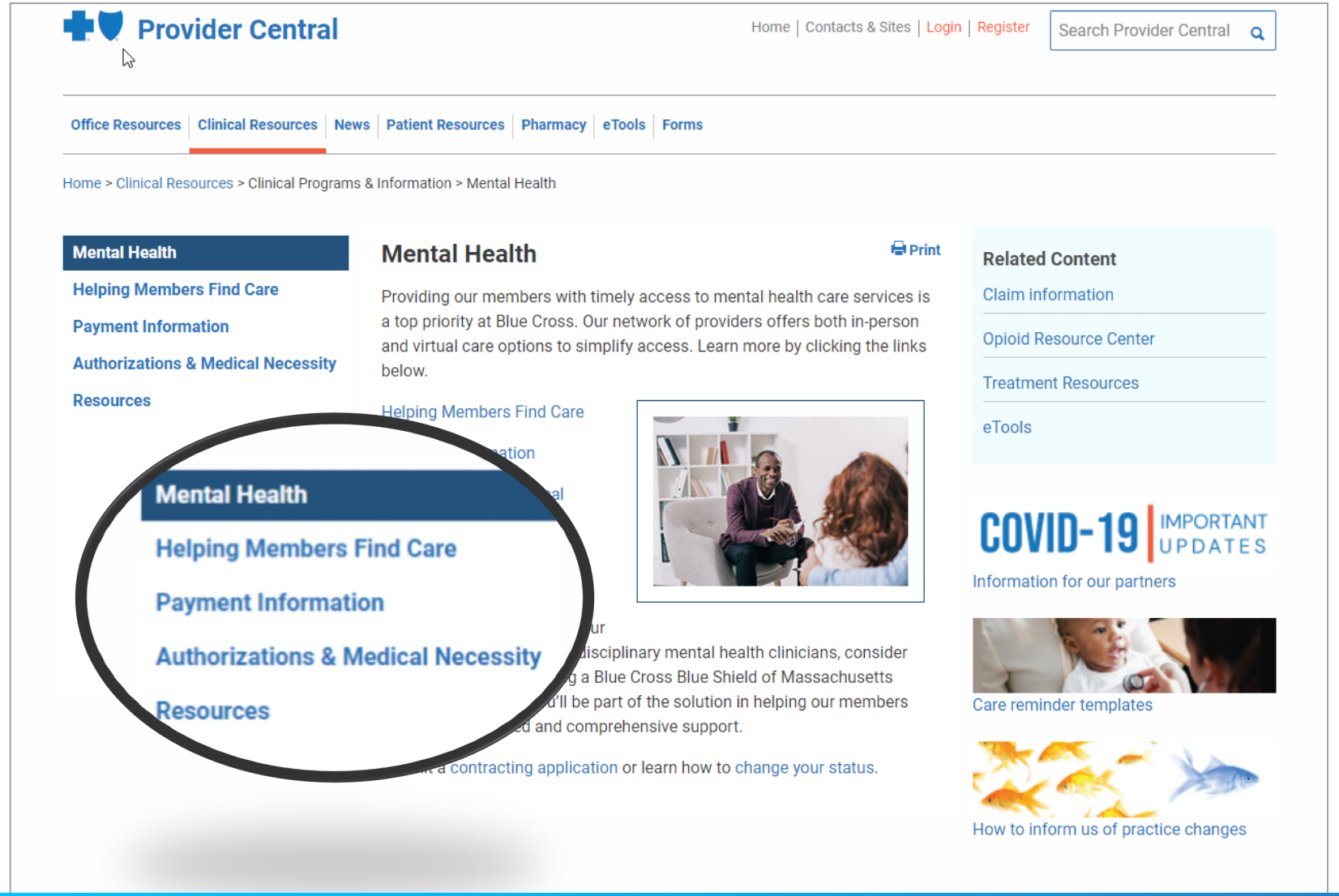
Member Service Manager

OVERVIEW

Our goal is to be the number one health plan for mental health by informing and educating providers on the company's mental health programs and resources.

- Navigate members in need of mental health care to affordable and appropriate care
- Expand our network of mental health care providers to improve access
- Promote care models integrating both physical and mental care

INTRODUCING OUR NEW MENTAL HEALTH PAGE ON PROVIDER CENTRAL



- Central hub consolidates mental health administrative information and related resources
- Details comprehensive information about mental health programs
- Archives past *Mental Health Brief* e-newsletter issues

Launched March 1, 2023

ONE-STOP-SHOP

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Payment information – reimbursement criteria, relevant fee schedules and payment policies, and other payment-related tools

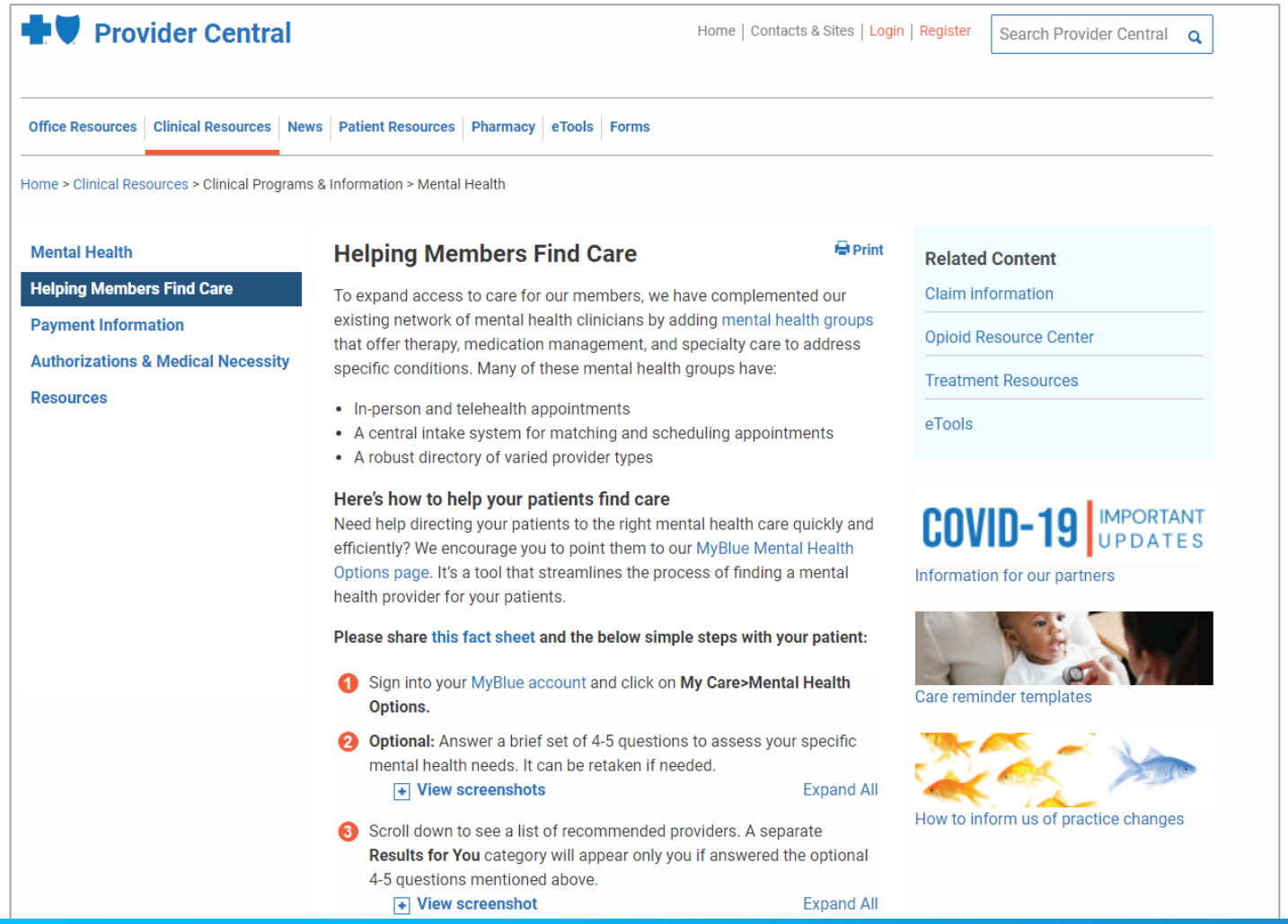
Authorizations & medical necessity – information about authorization requirements and medical necessity guidelines for various levels of care

Resources – helpful resources for mental health providers and PCPs to review and share with their patients, including past issues of our MH Brief e-newsletter and links to Coverage, treatment resources, and more

SPOTLIGHT ON

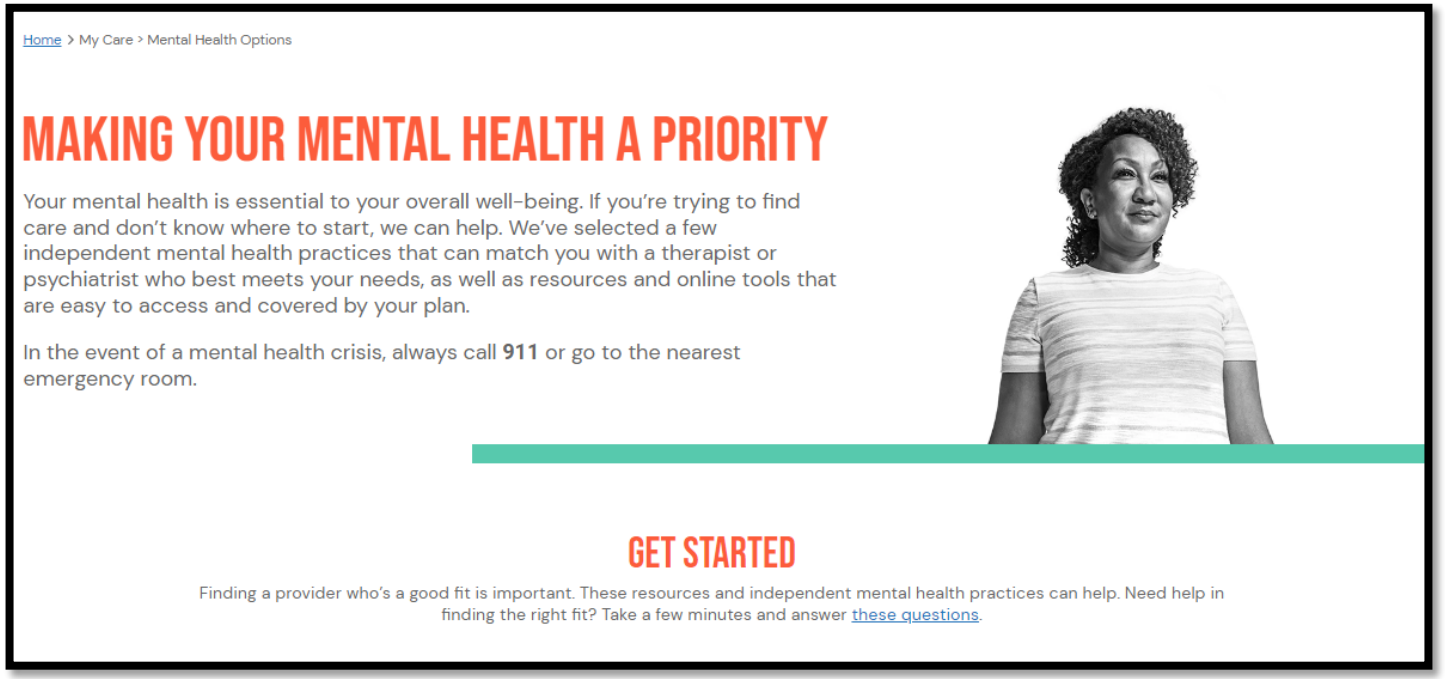
HELPING MEMBERS FIND CARE

HELPING MEMBERS FIND CARE



- Overview of the various mental health options, both in-person and virtual, available to our members
- Detailed list of steps and screenshots describing how members can search for mental health care via MyBlue
- Organized tables of mental health groups and their offerings

HELPING MEMBERS FIND CARE CONT.



Our MyBlue Mental Health Options page makes finding care simple and fast. Here, members can answer 4-5 questions to assess their specific needs and review a personalized list of providers that might be a good fit for them.

HELPING MEMBERS FIND CARE CONT.

Mental health groups

Below is a list of the mental health provider groups your patients will see as options on our site. Click each category to learn more.

- **Virtual primary care provider with mental health** Expand All
- **Groups offering therapy and medication management**
- **Groups offering specialty mental health care**
- **Employee Assistance Program (EAP) and self-management**

Provider directory

Provider participation: If you need to verify if a particular provider is in our network, you can view our Find a Doctor & Estimate Costs tool.

Keep your directory information up to date: We use the information you enter in CAQH ProView to update our provider directory, so it is important to validate your information quarterly. If you do not keep your data current, or if you do not regularly review and attest to its accuracy, you could be removed from our directory. **If you are a facility or group practice**, we'll reach out to you throughout the year to review and validate your information.

Name	Patient ages accepted	Virtual options offered?	In-person visits offered?
Headway	6 years and up	Yes	Yes
Refresh Mental Health	4 years and up	Yes	Yes
Talkiatry	6 years and up	Yes	No
Thriveworks	6 years and up for therapy 14 years and up for medication management	Yes	Yes
Valera Health	6 years and up	Yes	Yes

TELEHEALTH AND CPT HCPCS MODIFIERS PAYMENT POLICIES

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Telehealth – Mental Health

Payment policy

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Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted health care providers for covered, medically necessary mental health telehealth services.

This payment policy describes reimbursement for telehealth (telemedicine) and other electronic communication services in line with Chapter 260 of the Acts of 2020: The Patients First Act, which occur when the physician or other qualified health care professional and the patient are not at the same site. Examples of such services are those that are delivered via the telephone or using other communication devices. Any and all parts of this payment policy may be changed to comply with regulations or guidance from the Division of Insurance.

Blue Cross providers must deliver telehealth and telephone services via a secure and private data connection. All transactions and data communication must comply with the Health Insurance Portability and Accountability Act (HIPAA). For more information on HIPAA and electronic protected health information (EPHI) compliance, please see: https://www.hhs.gov/hipaa/for-professionals/index.html

Telehealth services are reimbursed when:

- The provider is contracted with Blue Cross Blue Shield of Massachusetts or is providing services through a telehealth vendor contracted with Blue Cross Blue Shield of Massachusetts.
- The provider renders care from the location listed in his or her contract with Blue Cross Blue Shield of Massachusetts or other appropriate location(s), in a professional, non-public space.
- The provider must be licensed in accordance with applicable state law in the state where the member is physically located during the telehealth visit and meet all terms and conditions of the applicable contracts, including credentialing and licensure. It is up to the provider to comply with Federal and state legislative rules on telehealth.

CPT® and HCPCS® Modifiers

Payment policy

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Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) accepts **industry-standard** modifiers to allow for clear provider reporting of services and accurate claims processing.

Modifiers designate a reported service or procedure performed that has been noted by specific criteria without changing the procedure code. Some examples a modifier may be used to indicate are:

- A bilateral procedure
- An unusual circumstance
- The professional or technical component of a service has been performed
- Service performed on right or left side of the body

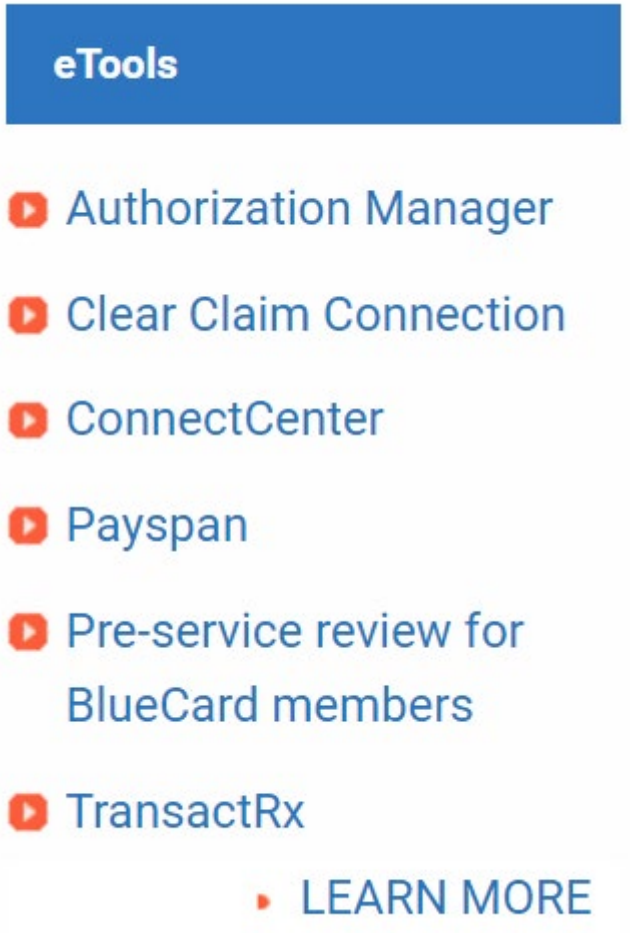
General benefit information

Covered services and payment are based on the member's benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members' costs depend on member benefits.

Certain services require prior authorization or referral.

CONNECTCENTER

- ConnectCenter is a tool that both medical and mental health providers can use to submit claims and to perform most real-time transactions. It is owned and maintained by Change Healthcare.
- With ConnectCenter, you can:
- Check member benefits and eligibility
- Check the status of your claims
- Enter and verify referrals
- Submit and track professional 1500 claims and replacement claims using Direct Data Entry (DDE)
    - Payspan users: There is no impact to your claim payments when you start using ConnectCenter to submit claims

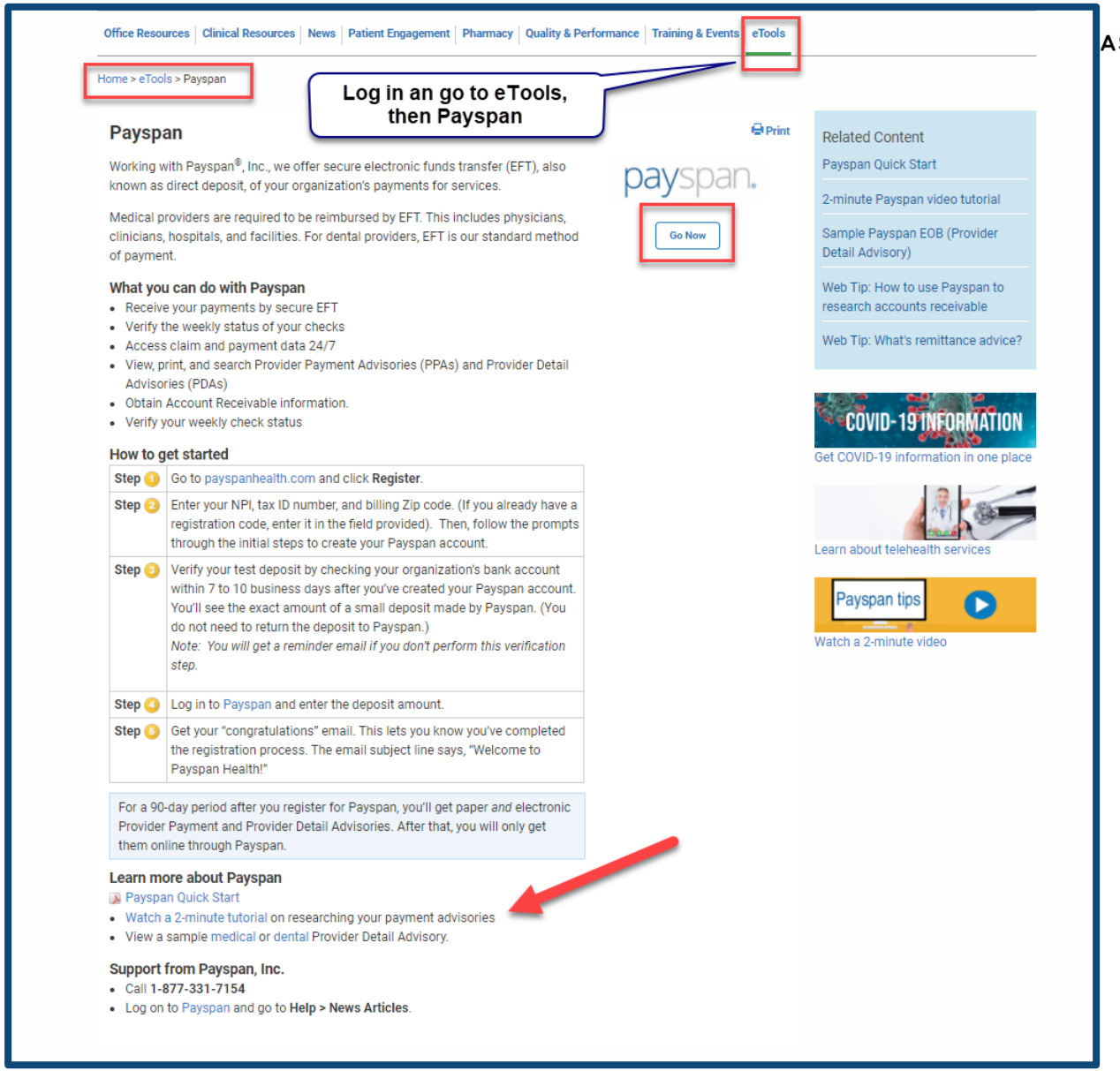


CHECKING THE STATUS OF A CLAIM

Accessing Payspan

Log in to Provider Central and go to eTools, then Payspan

- Click the Go Now button to be taken over to Payspan
- On this page, you'll also find resources and tips for using the tool



CHECKING THE STATUS OF A CLAIM CONT.

What is Payspan?

Payspan (payspanhealth.com) is a web-based system for tracking and managing payments and claims data.

You can use Payspan to:

- Receive secure direct deposits into your bank account
- View, print, and save your provider advisories
- Obtain Accounts Receivable information
- Access claim and payment data 24/7

Payspan contact information: **1-877-331-7154**

Viewing your provider detail advisories

- Watch a 2-minute tutorial

Payspan Webinars- How to Register and Use the Provider Portal

November 15, 2023 | 1:30PM - 3:00PM EDT

https://fuze.me/webinars/register/1166122

December 20, 2023 | 1:30PM - 3:00PM EDT

https://fuze.me/webinars/register/1166126

CHECKING THE STATUS OF A CLAIM CONT.

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Blue Cross Blue Shield of Massachusetts is an Independent Licensee of the Blue Cross and Blue Shield Association

Provider Detail Advisory

Professional

CONTACT INFORMATION

Physicians: 1-800-882-2060
Hospitals: 1-800-451-8123
Ancillary/Mental Health: 1-800-451-8124
Dental: 1-800-882-1178
Out-of-State Providers - Eligibility, benefits, and claim status information is available by calling: 1-800-676-2583
Out-of-State Providers - Please note your BCBSMA courtesy 'provider number'

PROVIDER NUMBER	PROVIDER	PAYMENT	SYSTEM INDICATOR
[redacted]			N

	Patient Account #	BCBSMA Responsibility
[redacted]		PRIMARY

Claim Number [redacted] Type of Bill 021

Click to view Payment Advisory

Line #	Date of Service	Modifier(s)	Place of Service	Line Msg Indicator	Submitted Procedure:	Submitted Units:
1	11/05/2020 -11/05/2020	GT	3	A B	90837	1

Line Charge	Allowed	Contractual	Payer Initiated	OA	Copay	Deductible	Coinsurance	Other Patient Responsibility	Withhold	Paid
$150.00	$0.00	$150.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Grand Totals:

Line Charge	Allowed	Contractual	Payer Initiated	OA	Copay	Deductible	Coinsurance	Other Patient Responsibility	Withhold	Paid
$150.00	$0.00	$150.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

A - CO 29 The time limit for filing has expired. (HIPAA Codes)

B - THIS CLAIM WAS SUBMITTED AFTER THE FILING DEADLINE. FOR MEDICAL, IF YOU HAVE PROOF YOU FILED ON TIME, PLEASE SEND DOCUMENTATION TO BLUE CROSS BLUE SHIELD OF MASSACHUSETTS APPEALS, PO BOX 986065, BOSTON, MA 02298-6065. FOR DENTAL, IF YOU HAVE PROOF THAT YOU FILED ON TIME, PLEASE SEND DOCUMENTATION TO BLUE CROSS BLUE SHIELD OF MASSACHUSETTS APPEALS, PO BOX 986010, BOSTON, MA 02298-6065. /B092/

REPLACEMENT CLAIMS

We require providers to submit a replacement claim instead of calling or submitting an appeal when the claim is:

- Fully denied, partially denied, or needs to be voided
- Where do you put the replacement claim info when submitting a claim?
  - When submitting electronically
    - In the 2300 Loop, the CLM segment (Claim Information) CML05-03 (Claim Frequency Type Code) “7” – Replacement (replacement of prior claim)
  - When submitting on paper
    - Professional claim – Field 22, Facility claim – third digit of the type of bill

Frequency codes

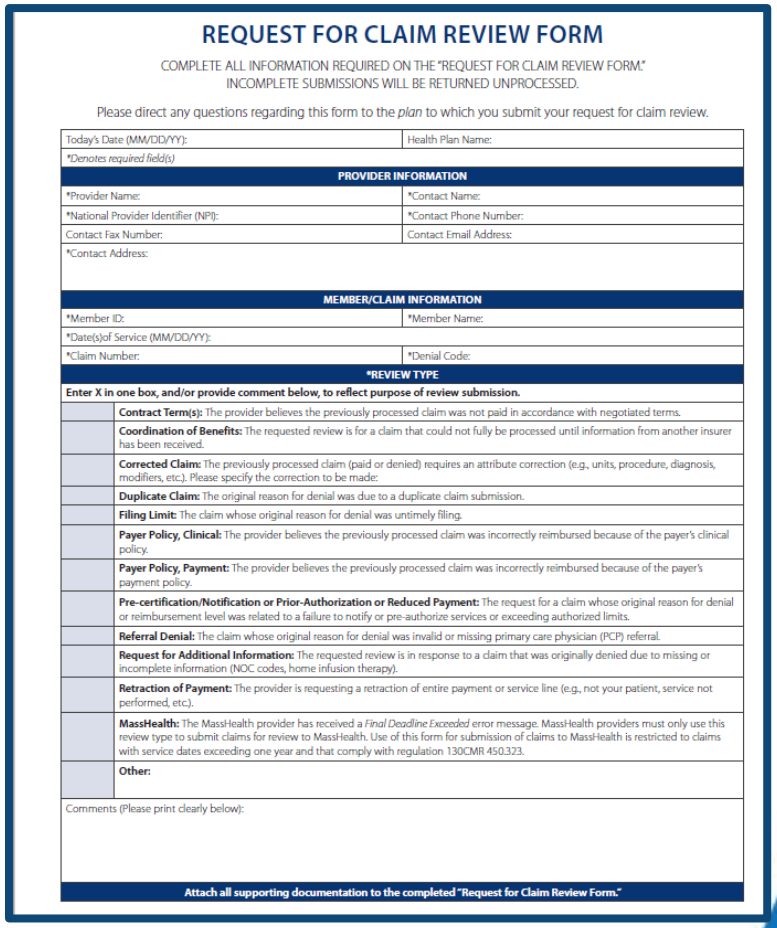
- Late charges: frequency code 5
- Replacement claim: frequency code 7
- Full void: frequency code 8
  - Once voided, the claim is done; nothing more can be changed

REPLACEMENT CLAIMS CONT.

- Reminder – Put the claim number in there!
  - For electronic claims, enter the ICN into REF02 with qualifier = F8
  - For paper 1500 claims, enter the ICN in Item 22, Original Ref No.
- Do not submit a replacement claim for:
  - Appeals – If you are appealing a claim, send it in writing with the appropriate documentation to:

    Blue Cross Blue Shield of Massachusetts Appeals
    PO Box 986065

    Boston, MA 02298
  - If you are not making any changes, do not submit a replacement claim
  - Member ID changes
  - Claims that are past timely filing guidelines
    - One year from the processing date as long as you are not adding lines or charges



REQUEST FOR CLAIM REVIEW FORM

COMPLETE ALL INFORMATION REQUIRED ON THE "REQUEST FOR CLAIM REVIEW FORM."
INCOMPLETE SUBMISSIONS WILL BE RETURNED UNPROCESSED.

Please direct any questions regarding this form to the *plan* to which you submit your request for claim review.

Today's Date (MM/DD/YY):	Health Plan Name:
Denotes required field(s)	
PROVIDER INFORMATION	
*Provider Name:	*Contact Name:
*National Provider Identifier (NPI):	*Contact Phone Number:
Contact Fax Number:	Contact Email Address:
*Contact Address:	
MEMBER/CLAIM INFORMATION	
*Member ID:	*Member Name:
*Date(s)of Service (MM/DD/YY):	
*Claim Number:	*Denial Code:
***REVIEW TYPE**	
Enter X in one box, and/or provide comment below, to reflect purpose of review submission.	
	Contract Term(s): The provider believes the previously processed claim was not paid in accordance with negotiated terms.
	Coordination of Benefits: The requested review is for a claim that could not fully be processed until information from another insurer has been received.
	Corrected Claim: The previously processed claim (paid or denied) requires an attribute correction (e.g., units, procedure, diagnosis, modifiers, etc.). Please specify the correction to be made:
	Duplicate Claim: The original reason for denial was due to a duplicate claim submission.
	Filing Limit: The claim whose original reason for denial was untimely filing.
	Payer Policy, Clinical: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's clinical policy.
	Payer Policy, Payment: The provider believes the previously processed claim was incorrectly reimbursed because of the payer's payment policy.
	Pre-certification/Notification or Prior-Authorization or Reduced Payment: The request for a claim whose original reason for denial or reimbursement level was related to a failure to notify or pre-authorize services or exceeding authorized limits.
	Referral Denial: The claim whose original reason for denial was invalid or missing primary care physician (PCP) referral.
	Request for Additional Information: The requested review is in response to a claim that was originally denied due to missing or incomplete information (NOC codes, home infusion therapy).
	Retraction of Payment: The provider is requesting a retraction of entire payment or service line (e.g., not your patient, service not performed, etc.).
	MassHealth: The MassHealth provider has received a *Final Deadline Exceeded* error message. MassHealth providers must only use this review type to submit claims for review to MassHealth. Use of this form for submission of claims to MassHealth is restricted to claims with service dates exceeding one year and that comply with regulation 130CMR 450.323.
	Other:
Comments (Please print clearly below):	
Attach all supporting documentation to the completed "Request for Claim Review Form."	

Reminder – Do not send replacement claims to the appeals address

APPEAL STATUS

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Reminder: Allow time for appeals to be reviewed

Print

September 1, 2021

This article is for all providers caring for our members

As a reminder, we process appeals in the order we receive them. You may call Provider Service to hear an automated message that lists the received dates of the appeals that we are currently reviewing.

Once your appeal is reviewed, we'll notify you of our decision by letter, fax, or an adjusted Explanation of Benefits.

We appreciate your patience and understanding.

APPEAL STATUS CONT.

IVR message below:

"We process appeals in the order they are received. Please allow additional time as we are currently reviewing Professional appeals received on (Date), Facility appeals received on (Date), Blue Card appeals received on (Date), Medicare Advantage appeals received on (Date), and Home Infusion Therapy appeals received on (Date). Once your appeal is reviewed, we'll notify you of our decision by letter, fax, or an adjusted Explanation of Benefits. To repeat this message, press 1. Otherwise, press 2."

*FEP dates are provided when calling the FEP Claims line.

APPEAL STATUS CONT.

TIMELY FILING

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Timely filing guidelines

Member's plan	Timely filing guideline
Federal Employee Program	90 days from the date of service
Commercial/Medicare Advantage	90 days from the date of service
Medex	One year from the Medicare explanation of benefits
Indemnity	One year from the date of service
BlueCard	90 days from the date of service

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QUESTIONS?

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THANK YOU