May 27, 2021

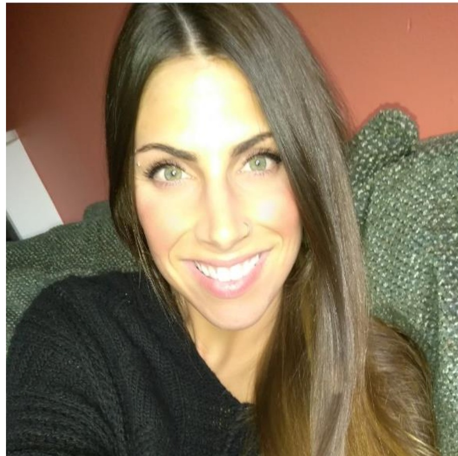
LIFE CYCLE OF A CLAIM

A WEBINAR FOR MEDICAL PROVIDERS

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

PRESENTERS

MASSACHUSETTS



Chelsea G.

Provider Service Supervisor

Chelsea S.

Provider Service Business Consultant

MASSACHUSETTS

- Verifying Benefits/Eligibility
- Verifying Billing Guidelines and Medical Necessity
- Submitting a Claim
- Status of a Claim
- Following up on a Claim
- Provider Central – Claim Submission Resources
- Questions

QUESTIONS?

USE THE Q/A FEATURE

Test Survey

The event is live - You are in a view and listen only role and can not be seen or heard DISMISS

Test Survey

All cameras are turned off

The event is live

BlueJeans DOLBY VOICE

May 27, 2021

LIFE CYCLE OF A CLAIM

CC

BlueJeans by Verizon

Dolby Voice

- Closed-captioning is available – lower left
- Slider bar at the bottom to increase the size of visuals
- Q&A button – right side of the screen to submit a question
- Chat- right side of your screen

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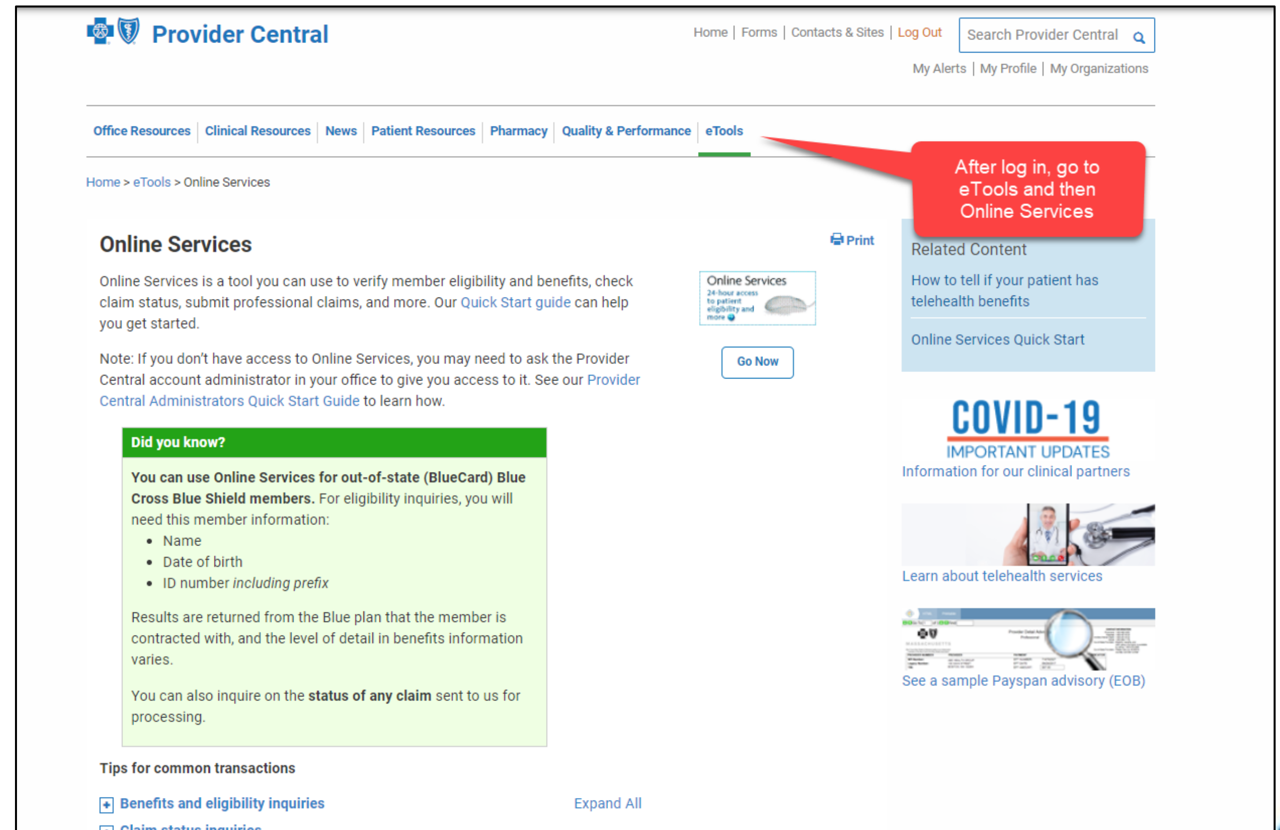
VERIFYING BENEFITS AND ELIGIBILITY

MASSACHUSETTS

Verify benefits and eligibility before rendering services

- Use a tool like Online Services (available through Provider Central)
  - Still need help after checking online?
    - Call Provider Service
    - Call BlueCard eligibility for members of another Blue Plan receiving care in Massachusetts (1-800-676-BLUE [2583])

Authorization/Referral requirements are determined by the member's plan



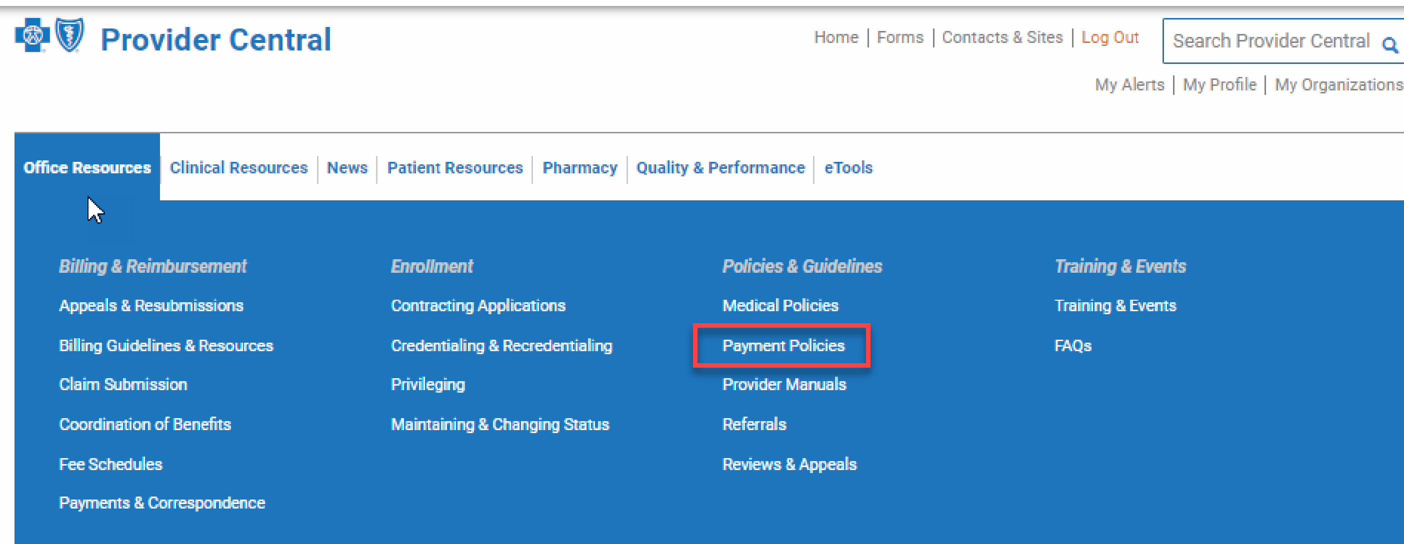
To access Online Services: Log in to bluecrossma.com/provider and click eTools>Online Services

PAYMENT POLICY

MASSACHUSETTS

Our payment policies help providers understand the way a submitted claim for services will be processed and paid.

- Payment policies are posted to Provider Central (log in required)



Telehealth (Telemedicine) – Medical Services

Payment Policy

This policy no longer contains COVID-19 specific information. Please refer to the COVID-19 Temporary Payment Policy for policy-specific information related to COVID-19. Information in the COVID-19 Temporary Payment Policy supersedes other Blue Cross payment policies for the duration of the Massachusetts state of emergency.

Policy

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

In line with Chapter 224 of the Acts of 2012, Blue Cross defines telemedicine as *the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment*. Telehealth (telemedicine) does not include the use of audio-only telephone, fax machine, or email.

Blue Cross providers must deliver telehealth (telemedicine) services via a secure and private data connection. All transactions and data communication must be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). For more information on HIPAA and electronic protected health information compliance, please see: hhs.gov/ocr/privacy/hipaa/understanding/srsummary.html.

Asynchronous telecommunication
Medical information is stored and forwarded to be reviewed at a later time by a physician or health care practitioner at a distant site. The medical information is reviewed without the patient being present. Asynchronous telecommunication is also referred to as **store-and-forward telehealth** or **non-interactive telecommunication**.

Interactive audio and video telecommunication
Medical information is communicated in real-time with the use of interactive audio and video communications equipment. The real-time communication is between the patient and a distant physician or health care specialist who is performing the service reported. The patient must be present and participating throughout the communication.

Telehealth
Telehealth is a broader term which includes telemedicine.

CPT® and HCPCS® Modifiers

Payment policy

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) accepts **industry-standard** modifiers to allow for clear provide 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 off staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eT page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayment deductibles, and co-insurance. Members' costs depend on member benefits.

Certain services require prior authorization or referral.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

General reimbursement information

- Modifiers may affect how claims are processed, how services are priced, and how payment is calculated. Modifiers also affect how we apply member benefits.
- Claims submitted with modifiers are subject to pre and/or post-pay audit. Medical notes must support services identified by the modifier.
- Blue Cross accepts all standard current procedural terminology (CPT) and healthcare common procedure coding system (HCPCS) modifiers submitted in accordance with the appropriate procedure codes. Certain modifiers, when submitted appropriately, will impact reimbursement.
- The absence or presence of a modifier may result in a claim denial.

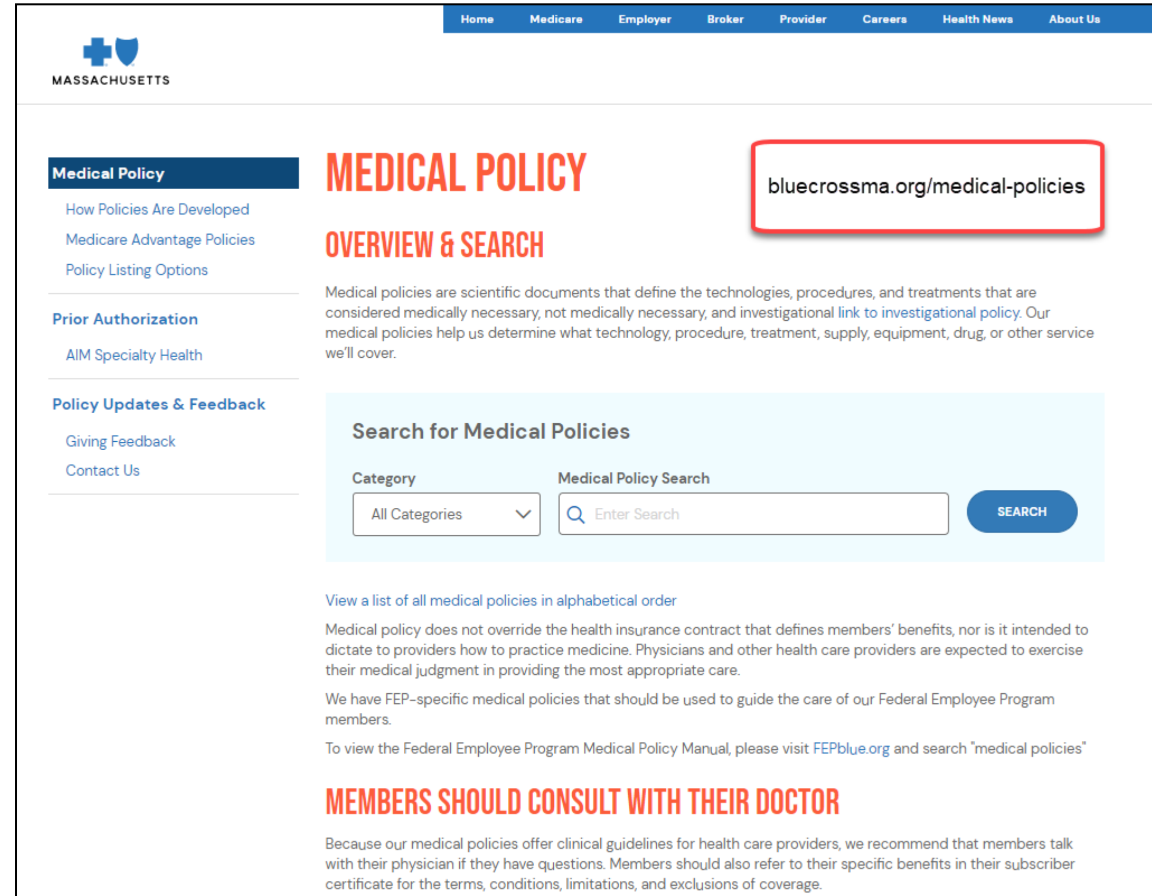
Modifier 25: Significant, separately identifiable evaluation and management (E/M) service

- Modifier 25 indicates a significant, separately identifiable E/M service by the same provider or other qualified heal care professional on the same day of the procedure or other service. A significant, separately identifiable E/M servi

MEDICAL POLICY

Our medical policies help providers understand how we cover services, based on medical necessity criteria. We use scientific evidence and clinical guidelines to determine medical necessity.

- Medical policies are posted to Provider Central (anyone can access them)
- Search by:
  - Policy name or number
  - Category
  - Code (type in the CPT or HCPCS code into the search window)

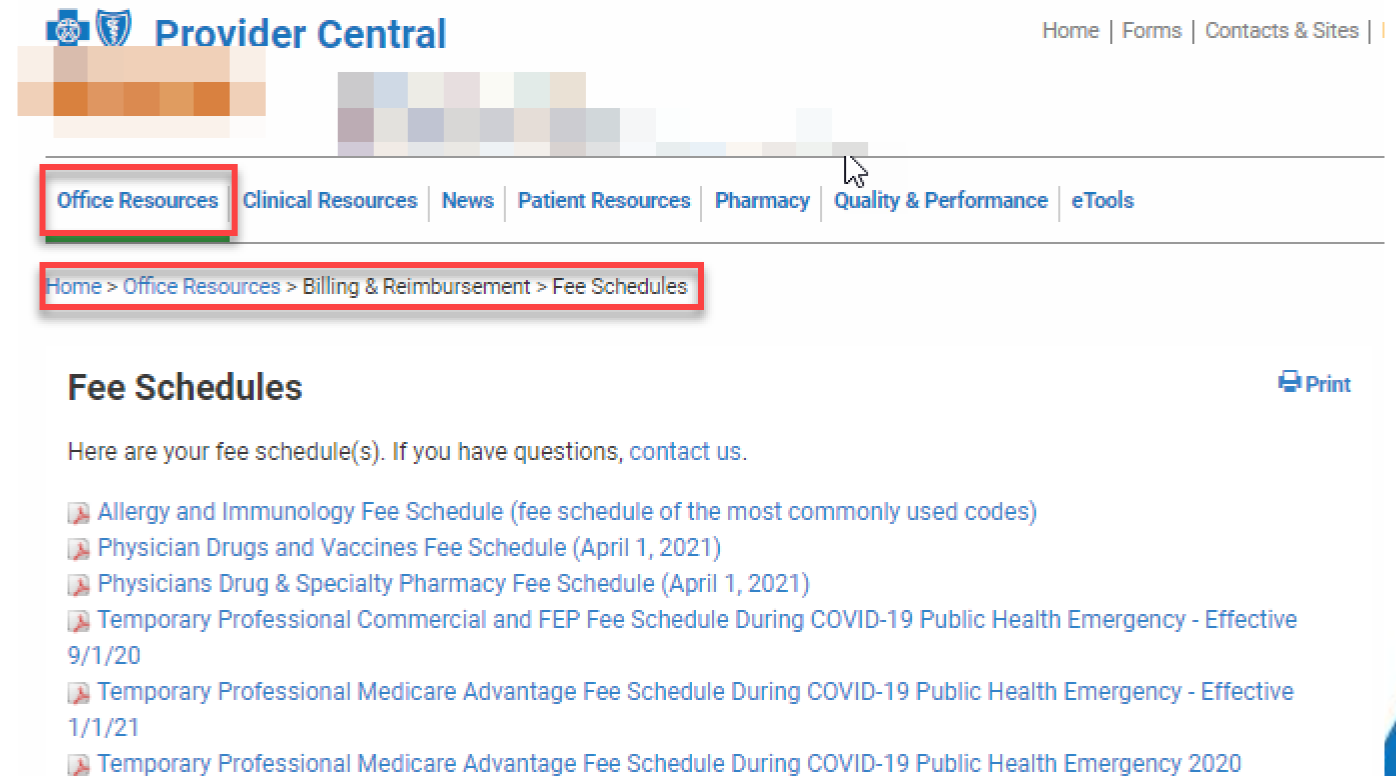


To access Federal Employee Program (FEP) medical policies visit: fepblue.org and search for medical policies

FEE SCHEDULE

We post fee schedules on Provider Central where you can see a list of codes and the fees that you are contracted for.

- Log in and go to **Office Resources>Billing & Reimbursement** and then to your fee schedule.



MASSACHUSETTS

Where do I submit claims?

- Claims should be submitted to Blue Cross Blue Shield of Massachusetts when services are rendered in Massachusetts. This includes BlueCard and FEP members.
  - For members with Blue Benefit Administrators (BBA), please send claims to BBA

How should I submit claims?

- Electronically
  - Direct Data Entry (tool we offer through Provider Central for professional claims only)
- Paper claims: still accepted

Office Resources | Clinical Resources | News | Patient Resources | Pharmacy | Quality & Performance | eTools

Home > eTools > Online Services

Online Services

Print

Online Services is a tool you can use to verify member eligibility and benefits, check claim status, submit professional claims, and more. Our Quick Start guide can help you get started.

Go Now

Note: If you don't have access to Online Services, you may need to ask the Provider Central account administrator in your office to give you access to it. See our Provider Central Administrators Quick Start Guide to learn how.

Did you know?

You can use Online Services for out-of-state (BlueCard) Blue Cross Blue Shield members. For eligibility inquiries, you will need this member information:

- Name
- Date of birth
- ID number *including prefix*

Results are returned from the Blue plan that the member is contracted with, and the level of detail in benefits information varies.

You can also inquire on the **status of any claim** sent to us for processing.

Learn how to set up and use Direct Data Entry

Tips for common transactions

Benefits and eligibility inquiries Expand All

Claim status inquiries

Information about Direct Data Entry, a tool for submitting only professional 1500 claims:

- Direct Data Entry Set-up & User Guide
- How to register for Direct Data Entry in Online Services
- How to enter claims using Direct Data Entry in Online Services
- How to view Direct Data Entry reports in Online Services

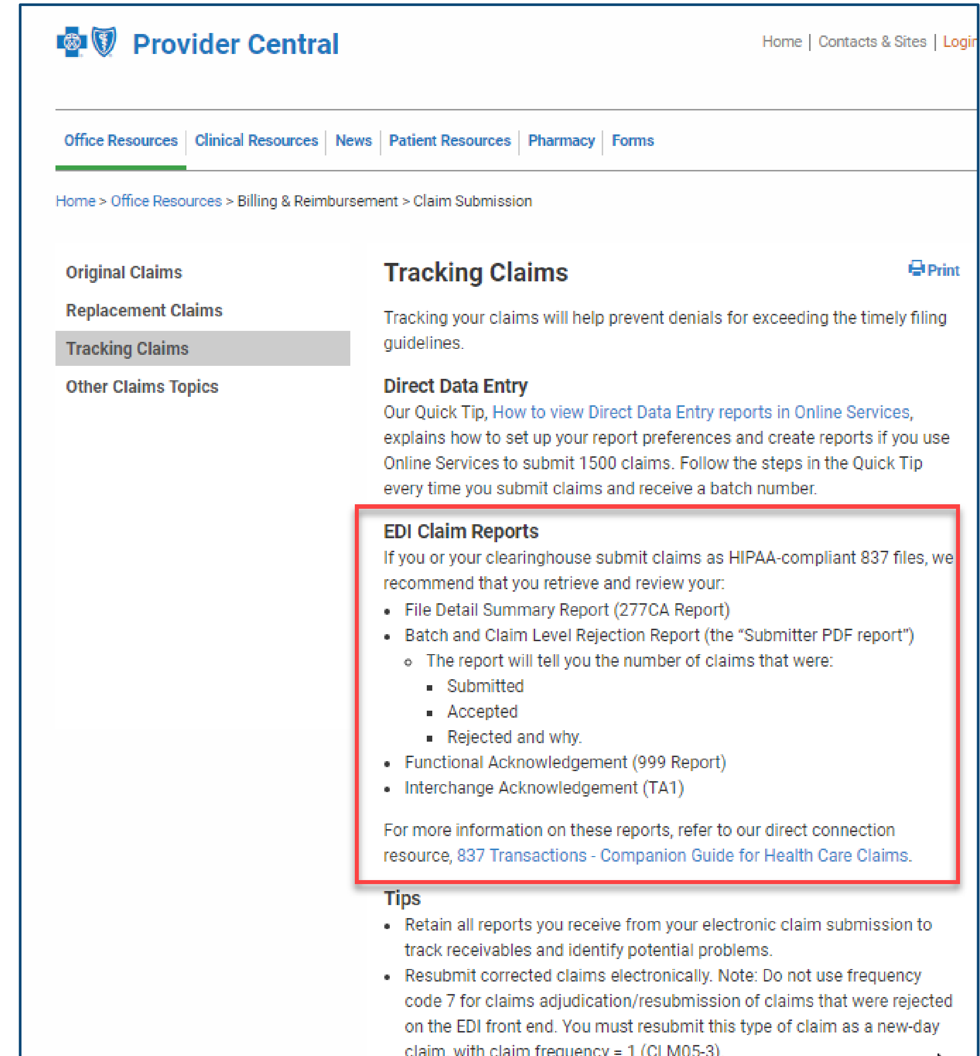
MASSACHUSETTS

Top factors that impact your claims processing:

- ✓Submit the member's information as you see it when you verified eligibility (include their prefix). Example: Robert Smith versus Bob Smith
- ✓Consider timely filing guidelines and get claims to us as soon as possible
- ✓Include the place of service and bill the appropriate modifier on telehealth claims
- ✓If Blue Cross and Blue Shield is secondary, please submit the primary values with the secondary claim
- ✓If Medicare is primary, please allow time before submitting a secondary claim. Most times, Medicare will send the claim over to us or to the member's plan directly.

CHECKING THE STATUS OF THE CLAIM

- When billing electronically, please verify that we have accepted the claim (use reports from your clearinghouse)


Provider Central

Home | Contacts & Sites | Login

Office Resources | Clinical Resources | News | Patient Resources | Pharmacy | Forms

Home > Office Resources > Billing & Reimbursement > Claim Submission

Original Claims
Replacement Claims
Tracking Claims
Other Claims Topics

Tracking Claims

Print

Tracking your claims will help prevent denials for exceeding the timely filing guidelines.

Direct Data Entry

Our Quick Tip, How to view Direct Data Entry reports in Online Services, explains how to set up your report preferences and create reports if you use Online Services to submit 1500 claims. Follow the steps in the Quick Tip every time you submit claims and receive a batch number.

EDI Claim Reports

If you or your clearinghouse submit claims as HIPAA-compliant 837 files, we recommend that you retrieve and review your:

- File Detail Summary Report (277CA Report)
- Batch and Claim Level Rejection Report (the "Submitter PDF report")
  - The report will tell you the number of claims that were:
    - Submitted
    - Accepted
    - Rejected and why.
- Functional Acknowledgement (999 Report)
- Interchange Acknowledgement (TA1)

For more information on these reports, refer to our direct connection resource, 837 Transactions - Companion Guide for Health Care Claims.

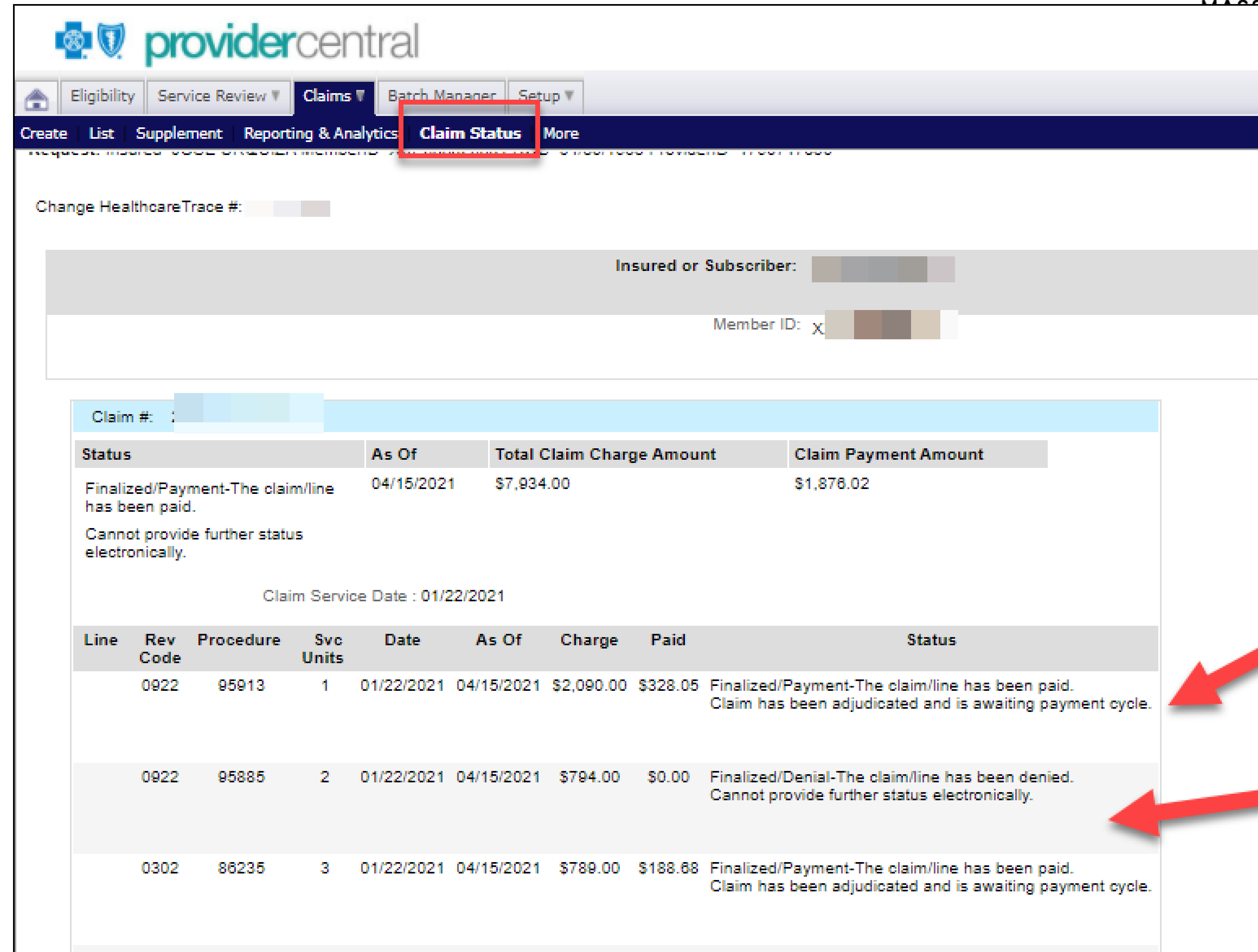
Tips

- Retain all reports you receive from your electronic claim submission to track receivables and identify potential problems.
- Resubmit corrected claims electronically. Note: Do not use frequency code 7 for claims adjudication/resubmission of claims that were rejected on the EDI front end. You must resubmit this type of claim as a new-day claim, with claim frequency = 1 (CLM05-3).

CHECKING THE STATUS OF A CLAIM

Use Online Services

- Claim processed
- Claim denied
- Claim is pending
  - Allow at least 45 days before following up with us



CHECKING THE STATUS OF A CLAIM

Accessing Payspan

MASSACHUSETTS

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

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

Office Resources | Clinical Resources | News | Patient Engagement | Pharmacy | Quality & Performance | Training & Events | eTools

Home > eTools > Payspan

Log in an go to eTools, then Payspan

Payspan

Print

Working with Payspan®, Inc., we offer secure electronic funds transfer (EFT), also known as direct deposit, of your organization's payments for services.

Medical providers are required to be reimbursed by EFT. This includes physicians, clinicians, hospitals, and facilities. For dental providers, EFT is our standard method of payment.

payspan.

Go Now

What you can do with Payspan

- Receive your payments by secure EFT
- Verify the weekly status of your checks
- Access claim and payment data 24/7
- View, print, and search Provider Payment Advisories (PPAs) and Provider Detail Advisories (PDAs)
- Obtain Account Receivable information.
- Verify your weekly check status

How to get started

Step 1	Go to payspanhealth.com and click **Register**.
Step 2	Enter your NPI, tax ID number, and billing Zip code. (If you already have a registration code, enter it in the field provided). Then, follow the prompts through the initial steps to create your Payspan account.
Step 3	Verify your test deposit by checking your organization's bank account within 7 to 10 business days after you've created your Payspan account. You'll see the exact amount of a small deposit made by Payspan. (You do not need to return the deposit to Payspan.) *Note: You will get a reminder email if you don't perform this verification step.*
Step 4	Log in to Payspan and enter the deposit amount.
Step 5	Get your "congratulations" email. This lets you know you've completed the registration process. The email subject line says, "Welcome to Payspan Health!"

For a 90-day period after you register for Payspan, you'll get paper *and* electronic Provider Payment and Provider Detail Advisories. After that, you will only get them online through Payspan.

Learn more about Payspan

Payspan Quick Start

- Watch a 2-minute tutorial on researching your payment advisories
- View a sample medical or dental Provider Detail Advisory.

Support from Payspan, Inc.

- Call **1-877-331-7154**
- Log on to Payspan and go to **Help > News Articles**.

Related Content

- Payspan Quick Start
- 2-minute Payspan video tutorial
- Sample Payspan EOB (Provider Detail Advisory)
- Web Tip: How to use Payspan to research accounts receivable
- Web Tip: What's remittance advice?

COVID-19 INFORMATION

Get COVID-19 information in one place

Learn about telehealth services

Payspan tips

Watch a 2-minute video

MASSACHUSETTS

- **What is Payspan?**

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

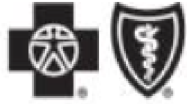
  You can use Payspan to:
  - Receive secure direct deposits into your bank account
  - View, print, and save your provider advisories
  - Obtain Accounts Receivable information.
  - Access claim and payment data 24/7
  - Payspan contact information: 1-877-331-7154

- **Viewing your provider detail advisories**
  - Watch a 2-minute tutorial

Payspan Webinars
How to Register and use the portal:

June 16, 2021 / 1:30pm – 3:00pm EST
https://fuze.me/webinars/register/1158698

July 21, 2021 / 1:30PM – 3:00PM EST
https://fuze.me/webinars/register/1158702



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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
			N

Patient Account #	BCBSMA Responsibility
	PRIMARY

Claim Number	Type of Bill
	021

Click to view Payment Advisory

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

Submitted Procedure: 90837 **Submitted Units:** 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/

MASSACHUSETTS

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 submitted 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 - CONTINUED

MASSACHUSETTS

- 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

MASSACHUSETTS

If your claim rejects and you want to correct it, please use the messages listed on your Provider Detail Advisory. We also offer a Quick Tip document.

P141

Reject code	HIPAA code	Message	What you need to know
P141	204	We cannot pay this service because the service you performed or item you provided is not part of your contract. HIPAA standard adjustment reason code narrative: This service/equipment/drug is not covered under the patient's current benefit plan.	The service you billed is not listed on your fee schedule.

What can you do?

Verify the fee schedule for the provider rendering the service. You can get the fee schedule on Provider Central by clicking **Office Resources>Billing & Reimbursement>Fee Schedules**.

MASSACHUSETTS

- If you disagree with the outcome of a claim, you have a right to appeal the decision.

Blue Cross Blue Shield of Massachusetts Appeals
PO Box 986065
Boston, MA 02298

- Clinical Appeals

Clinical Appeals Coordinator
1 Enterprise Drive
Quincy, MA 02171

MASSACHUSETTS

Timely Filing

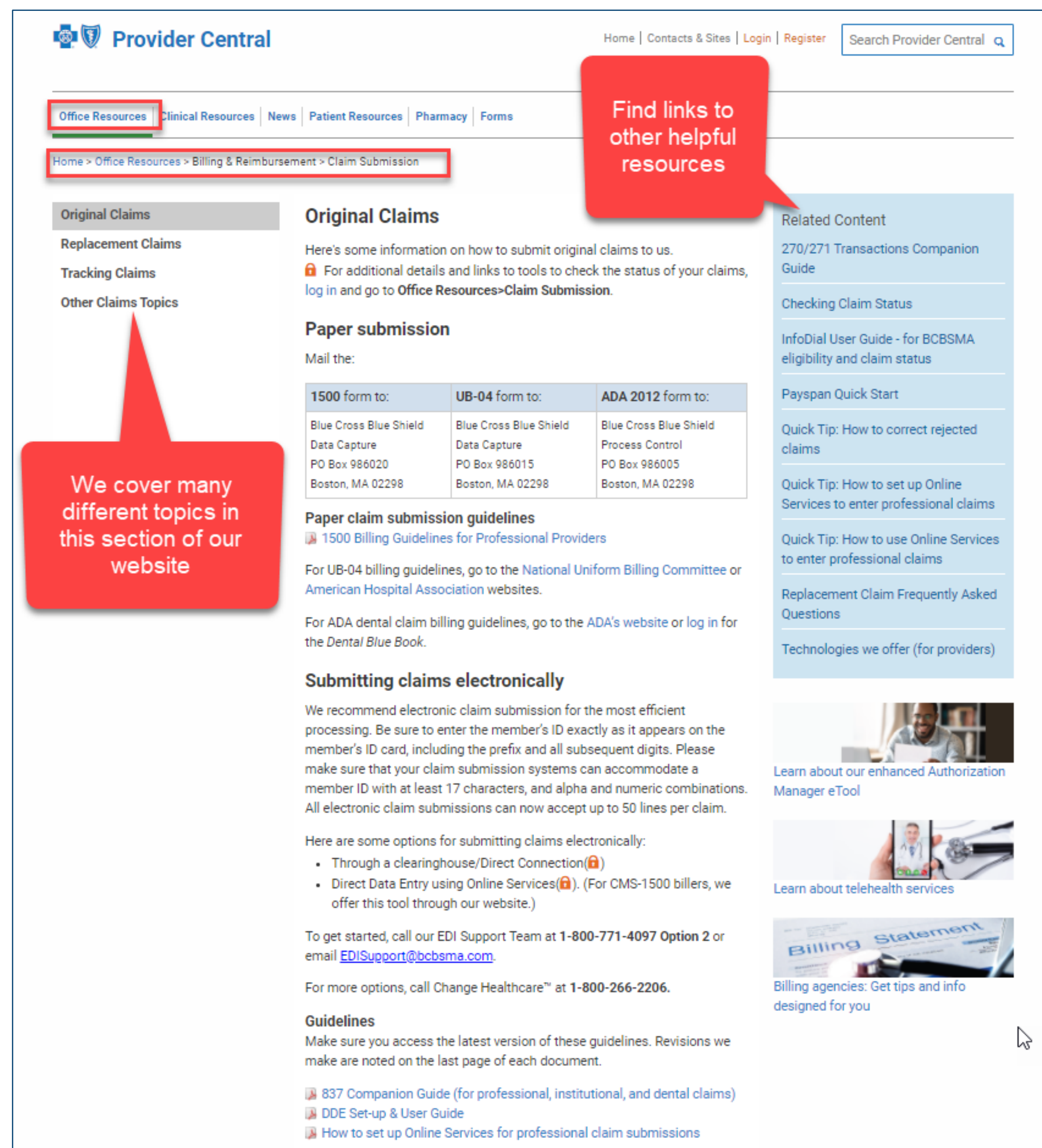
timely filing guidelines

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

PROVIDER CENTRAL OVERVIEW

For resources that we covered today:

- Visit bluecrossma.com/provider
- Go to Office Resources, then Billing & Reimbursement to fine Claim Submission resources



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QUESTIONS?

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

RESOURCES

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Billing Resources

- 837 Companion Guide (for professional, institutional, and dental claims)
- DDE Set-up & User Guide
- Claim Resubmission Guide (Frequency Codes 7 & 8)
- Late Charge Claim Request (Frequency Code 5) Guide
- Replacement Claim Requirement: Frequently Asked Questions
- Timely Filing Guidelines
- Use member ID prefix to find their Blue Plan: bcbs.com

Authorization Resources

- Prior authorization overview
- Behavioral health authorizations

Authorization Manager resources

- News article on Authorization Manager: tips and benefits
- Quick Tip