MASSACHUSETTS

ANSWERS TO WEBINAR QUESTIONS

Here are the answers to questions we received during the Life Cycle of a Claim webinar on May 27, 2021 and links to additional information on Provider Central.

- Provider Central: Learn more page. Includes links to Provider Central overview video, how to register guides, and more
- Claims information: Includes links to billing guidelines, timely filing guidelines, 837 Companion Guide, using Direct Data Entry (via Online Services) to submit claims to us electronically
- Replacement claims
- Payspan:
  - Quick Start Guide
  - Payspan 2-minute tutorial (how to read your Advisories)

APPEALS QUESTIONS

Q: Where do I send supporting documentation to appeal a denied claim (administrative appeal)?

A: If you've determined that you cannot submit a replacement claim, you can submit the *Request for Claim Review Form* and any documentation that you'd like us to review to:

Blue Cross Blue Shield of Massachusetts
Provider Appeals
PO Box 986065
Boston, MA 02298
For details on this process, please refer to our Reviews & Appeals page on Provider Central.

Q: What are clinical appeals?

A: Clinical reviews and appeals are conducted on utilization management denied requests for inpatient or outpatient services. You have 180 days from the date of service to file a clinical appeal to:

Blue Cross Blue Shield of Massachusetts
Clinical Appeals Coordinator
One Enterprise Drive
M/S 02-06
Quincy, MA 02171

For more information on the process for clinical appeals, please refer to our *Blue Book* provider manual by logging into Provider Central and going to **Office Resources**>**Policies and Guidelines**>**Provider Manuals**>**Reviews & Appeals**.

Q: Is there any way to submit appeals online or do they have to be mailed in?

A: All appeals should be submitted by mail.

Q: My claim denied for another insurance being primary, but that isn't true. Do I just keep submitting the claim, or do I appeal?

A: If Blue Cross incorrectly indicates that another insurance is primary, the member should update their coordination of benefits with each of their plans. Resubmitting the claim or appealing will not allow the claim to pay unless the member first corrects their information.

Q: If I'm not changing information on the claim, do I submit an appeal or resubmit the claim? For example: A licensed mental health counselor's claim denied for needing to bill Medicare, but I do not participate with Medicare.

A: Generally, you shouldn't resubmit your claim if you're not changing anything. Some exceptions include:

- Claim denied for no authorization, but you obtained one afterwards
- Claim denied for member not eligible, but their eligibility was updated afterwards

For your specific LMHC question, you should submit an appeal advising that, based on your specialty, you do not participate with Medicare. Please include your Medicare opt-out letter. Do not resubmit the claim, as that will just cause duplicate denials.

BENEFITS AND ELIGIBILITY QUESTIONS

Q: Where do I find a member's copayment, deductible, co-insurance, and their accumulations?

A: You can find this information and more by checking the member's benefits. Be sure to look at the appropriate benefit based on the service you're rendering.

- For any Blue Cross policies in or out-of-state, use Online Services in the **eTools** section of Provider Central.
- For out-of-state (BlueCard) members, you can call **1-800-676-BLUE (2583)** to speak with their plan directly.

For more information on using Online Services to check benefits and eligibility please review our Quick Start Guide.

Q: When we ask about a specific CPT code during benefit verification, we're told that benefits are based on medical necessity. Why?

A: We do not quote benefits for specific procedure or diagnosis codes. We only give general benefits because our call center associates are not clinicians. After reviewing benefits, you can search our medical policies to review any medical necessity criteria for your specific procedure. Go to bluecrossma.org/medical-policies and type your CPT code into the search bar.

Q: As of July 1, Blue Cross of Massachusetts will no longer waive copayments for telehealth sessions. Is that true? Also, how do we check if our patient will continue to be covered for telehealth sessions?

A: Effective July 1, 2021, we will reinstate member copayments, co-insurance, and deductibles for non-COVID-19 telehealth visits, including all mental and behavioral health services.

Note: These changes do not apply to our Medicare Advantage members. We are following guidelines from the Blue Cross Blue Shield Association regarding coverage for Federal Employee Program members. For more details, please see fepblue.org. For any Blue Cross policies in or out-of-state, use Online Services in the **eTools** section of Provider Central.

To verify benefits:

- For any Blue Cross policies in or out-of-state, use Online Services in the **eTools** section of Provider Central.
- For out-of-state (BlueCard) members, you can call **1-800-676-BLUE (2583)** to speak with their plan directly.

Refer to our telehealth page for information on using Online Services.

Q: If a patient doesn't pay their copayment at the time of service, will the payment remain pending, or will the claim be denied?

A: Claims will still process and finalize whether or not the member paid their copayment at the time of the visit. It will be your responsibility to bill the member for their copayment amount listed on your Provider Detail Advisory.

Q: Could you spend more time on verifying benefits at a future webinar?

A: We've received many questions about benefits at our Life Cycle of a Claim webinar, so we'll consider exploring this topic more in-depth for a future webinar. Thank you!

BLUECARD QUESTIONS

Q: Can I use Online Services to verify eligibility and benefits for BlueCard plans, including the ones with a strange ID? For example, some have a letter in the middle of the ID number.

A: You can look up these policies using Online Services in the **eTools** section of Provider Central. Otherwise, you can call **1-800-676-BLUE (2583)** to be routed to the member's plan.

Q: How do I speak with a representative when calling a Blue Plan whose phone system appears to be fully automated?

A: We encourage you to follow the fully automated system. It should still provide you with the information you need. Be sure to listen carefully and only input numbers when prompted.

- For information not available through the automated system, there will be an option for a live representative.
- For information that is available through the automated system, there won't be an option for a live representative.

Q: Can I check claim status for BlueCard members?

A: Yes, you can check status on Payspan, just as you would for a Blue Cross Blue Shield of Massachusetts member's claims.

Q: My claim was processed by a different Blue Cross plan outside of Massachusetts. What if I'm having trouble getting an explanation of benefits (EOB) from them?

A: Please follow up with that Blue Plan directly, as we can only help with EOBs for claims processed by Blue Cross Blue Shield of Massachusetts.

Q: My BlueCard claim denied as non-covered. I verified benefits with the member's 'home plan' and I was told that services should be covered. I appealed but received a response stating the claim denied correctly. What do I do?

A: For BlueCard claims, Blue Cross of Massachusetts doesn't maintain the member's benefits. If your claim denied as being non-covered, but you verified benefits, we dispute the denial on your behalf by working with the member's plan. If they respond to us saying the claim denied correctly, we're unable to take further action unless you have examples of the same exact service being paid for the same member. You can also contact the member's plan again or bill the member and have them appeal to their plan directly.

CLAIM SUBMISSION QUESTIONS

Q: I filed a claim, but it doesn't progress past my clearinghouse, so Blue Cross hasn't received it. What do I do?

A: Please work directly with your clearinghouse to determine the underlying issue. It could be an eligibility related error. Make sure that all the member information you submitted matches the information as it's listed in our eligibility files. Correct any identifiable errors and resubmit your claim.

Q: Can I electronically submit my claim with attachments after their Personal Injury Protection (PIP) carrier denied?

A: We do not accept electronic attachments. Please submit a paper claim by mail with all relevant documents attached.

MEDICAL AND PAYMENT POLICY QUESTIONS

Q: If a medical policy only lists certain payable diagnosis codes, does that mean any diagnosis code not listed will be denied?

A: This could vary depending on which medical policy you're referring to. However, this is typically true. Please be sure review our medical policies to prevent claim denials.

Q: If the member's plan is out-of-state, do I still follow Blue Cross of Massachusetts' payment and medical policies?

A: We reimburse you for BlueCard members following Blue Cross of Massachusetts **payment policies**. However, because the member's benefits are based on their out-of-state plan, you'll need to follow that plan's **medical policies**.

PAYSPAN QUESTIONS

Q: I have a private practice and do my own billing. Can I get access to Payspan? Is there a fee?

A: Yes, visit Payspanhealth.com for details on how to register. You'll need your NPI, tax ID number, and billing ZIP code (if you already have a registration code, enter it in the field provided). There is no fee. For help, call Payspan directly at **1-877-331-7154**.

Q: My claim has an adjudication date, but is not on Payspan and we haven't received payment or a denial. What does this mean?

A: This could mean that the claim is still in process. Please allow up to 45 days from the received date for a claim to finalize.

Q: What does "payer initiated" mean? My EOB doesn't have a copayment but has a payer initiated amount.

A: Payer initiated means that the service is not the responsibility of the member or Blue Cross.

Q: Are we able to get older EOBs on Payspan?

A: Yes, Payspan archives EOBs. For more information on exactly how far back you can go, call Payspan directly at **1-877-331-7154**.

PROVIDER CENTRAL QUESTIONS

Q: How do I access eTools on Provider Central?

A: Log in at bluecrossma.com/provider and click **eTools**. (If you aren't already registered for Provider Central, you'll need to do so to access our eTools.)

Q: What is the number I receive after submitting an electronic claim through Direct Data Entry on Provider Central?

A: You're most likely referring to a tracking number, which can be vendor specific. For example, you may receive a tracking number from Change Healthcare, or any other third-party clearinghouse you use. This is not the claim number. Blue Cross will generate a 14-digit ICN (claim number) once the clearinghouse forwards the claim to us.

Q: Can I sign up for email updates for Provider Central, or do I have to regularly check the website?

A: If you are registered for Provider Central and your email address is current, you should receive regular notifications – direct to your email box – from us on news and other updates published for your specialty. Our emails come from email@contact.emailbcbsma.com. Be sure to check your junk email box. If you're still having trouble, contact your network representative.

REFERRAL/AUTHORIZATION QUESTIONS

Q: Are referrals required for outpatient visits rendered out-of-state?

A: Referral and authorization guidelines are determined by the state in which the PCP is located. Please verify this information with the appropriate Blue Cross plan.

- For any Blue Cross policies in or out-of-state, use Online Services in the **eTools** section of Provider Central.
- For out-of-state (BlueCard) members, you can call **1-800-676-BLUE (2583)** to speak with the member's plan directly.

Q: If services are rendered in Massachusetts for a member who has a PCP in New Hampshire, which referral guidelines do I follow?

A: Please follow the referral and authorization guidelines of the state where the PCP is located.

Q: AIM told me no authorization is required, but then Blue Cross denied my claim for lack of authorization. What do I do?

A: AIM accepts retro-authorization requests within two business days of the date of service. If you are past that date, contact Blue Cross with the name of the AIM representative you spoke with, the date of the call, and the reference number. We will review your claim.

REFUND QUESTIONS

Q: What is the process to return money to Blue Cross?

A: If you need to return money to Blue Cross of Massachusetts, you may send a check to:

BCBSMA Cash Receipts
25 Technology Place
Hingham, MA 02043

Q: What is an offset?

A: If Blue Cross requests money back from you due to an overpayment, you should receive a letter from us notifying you of this request. The letter will tell you the amount you owe, the reason for retraction, the address to send money back to, and the due date.

If we have not received your refund by the due date, the money you owe us will be deducted from future claims until the owed amount is satisfied.

REPLACEMENT CLAIM QUESTIONS

Q: If a replacement claim is submitted by mail, how long does it take to show in Online Services on Provider Central?

A: It depends on the mail receipt date. Once we receive your claim, please allow up to 45 days for claim processing. For more efficient claim submission, we recommend sending electronic claims.

Q: When a patient has a status change (for example, observation to inpatient, or inpatient to outpatient, etc.) after the claim was already submitted, do you require the claim to be voided and then a new claim to be submitted?

A: Yes, you need to first void the existing claim that has the wrong level of care. Next, submit a new claim with the correct level of care.