Questions and Answers (Q & A)

October 16, 2024 webinar

Everything you need to know about claims

MASSACHUSETTS

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

Overview

If you attended our October 16 “Everything you need to know about claims” webinar, we hope you learned some tips and best practices on how to efficiently do business with us. Whether or not you attended, you can reference this document for a list of the questions we received before and during the event.

And here are additional resources related to the webinar:

- Webinar recording
- Slide deck

Questions and Answers

Q: What information do I need to have ready when calling Provider Service?

A: You should have the following information ready *before* you call Provider Service:

- Claim number
- Member ID number
- Member date of birth
- Date of service
- Total charges
- The issue or question you are calling about

Q: How long does it take for a claim to be processed and paid?

A: We generally process claims within 30 days of their receipt, and you should receive payment and claim processing details within 45 days of your submission. If you do not receive these within 45 days, you may contact Provider Service for assistance.

Q: Can I check pending claims on Payspan?

A: You can only review finalized claims on Payspan. To confirm if we received your claim, you can do so electronically or by calling InfoDial (**1-800-443-6657**).

Q: Do I need to log in to Payspan to see my claims?

A: Yes, you would need to register with Payspan and log in to access your claims.

Q: Was Payspan affected by the Change Healthcare incident?

A: No. You can continue to use Payspan as it was not impacted by the Change Healthcare incident. We hope that you feel more comfortable about navigating Payspan and understanding its capabilities after our webinar.

Q: Is it faster to submit a replacement claim via fax or mail?

A: The most efficient way to submit claims and replacement claims is electronically. If you are unable to do so, you can mail the claim.

Q: If my original claim denied for having an incorrect member date of birth, do I need to submit a replacement claim?

A: Yes. If you need to correct member information such as name, date of birth, or gender, you need to submit a replacement claim.

Q: Replacement claims using frequency code 5 still need to be submitted within timely filing limits (90 days from the date of service) right?

A: Yes.

Q: I've found that submitting frequency code 8 to fully void a claim doesn't seem to work sometimes– why?

A: When submitting a void request, please be sure that your information matches all aspects on the original claim exactly. Otherwise, our system may not be able to identify the correct claim.

Q: How can I determine if a member has an Indemnity plan?

A: You can verify member eligibility, including what type of plan they have, electronically or by calling into our benefits and eligibility line (**1-800-882-2060**).

Q: What's the best way to contact another state's Blue Cross Blue Shield plan to verify an out-of-state member's benefit and eligibility information?

A: You can verify an out-of-state member's benefits and eligibility information electronically or by calling **1-800-676-BLUE (2583)**. You'll need to enter the member's three-letter prefix from their ID number to be routed to their plan.

Q: What is the fax number for appeals?

A: You can fax appeals to **1-617-246-7168**.

Q: When I appeal a denied claim, I usually receive a letter stating that the claim processed correctly. But I wanted a clinical reviewer to look at the medical records and overturn the denial. What am I doing wrong?

A: If you received a letter stating that the claim processed correctly, it means that we reviewed your appeal and determined that the claim denial is correct based on our policies and the member's benefits. The medical records you supplied do not supercede these guidelines. We would suggest verifying coding on the claim.

Q: Can I appeal claims that denied for K788, U915, or E477?

A: For those denials, please review the appropriate medical policy for the denied CPT code in question. If you need to make a coding correction, please submit a replacement claim.

Q: Can I add a CPT code to an existing authorization via Authorization Manager?

A: If you need to make changes to an existing authorization, such as the date of service, codes, or units, you can fill out our Updates to Existing Authorizations form and fax it to us. You cannot make these changes on Authorization Manager.

Q: If my claim denies for timely filing, you said that I can bill the member for their copayments. Can I also bill them for their co-insurance and deductible?

A: No. You may not bill a member for their co-insurance or deductible on services that we denied due to being submitted after the timely filing limit. However, you may collect any applicable copayments.

Q: Where can I submit third-party liability appeals or documentation?

A: You can fax third-party liability appeals or documentation for Blue Cross Blue Shield of Massachusetts members (non-BlueCard) to **1-617-246-2093**.

Q: When a member's services are part of a motor vehicle accident (MVA) claim, but their plan falls under ERISA laws, they must meet their $8,000 PIP and not the $2,000 PIP, right?

A: Yes, that is correct.

Q: Do you reimburse therapy services rendered by a clinician in a school setting? Do I submit location code 03 for school, or 11 for office?

A: We do not reimburse for services related to the treatment and diagnosis of autism spectrum disorders when provided by school personnel or at a school location, including pursuant to an individualized education program (IEP).

Q: Where can I find information about podiatry reimbursement and billing guidelines?

A: Please refer to our Podiatry payment policy. To download our payment policies, log in and click **Find a Payment Policy** on the right side of your home page. Or, go to **Office Resources>Policies & Guidelines>Payment Policies**.

Q: Will you be ending your Provider Service Friday closures?

A: We currently have Friday closure days planned through the end of 2024. Our next two dates are November 8 and December 13. We are in the process of evaluating what these closure days may look like in 2025.

Q: I know that starting January 17, 2025, you're implementing multi-factor authentication for Provider Central. Will this include a text option, or only email?

A: You will need to authenticate via email, so we recommend that each user has their own email address to ensure you always receive the authentication emails.