SECTION 7: CLAIMS SUBMISSION
of the Member Provider Policy & Procedure Manual

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This section provides information about claims submission. If Blue Cross and Blue Shield of Louisiana makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this section and notify our network providers. For complete *Member Provider Policy & Procedure Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Member Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Member Provider Policy & Procedure Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

Section 7: CLAIMS SUBMISSION

FILING CLAIMS

- All claims must indicate if work-related injuries or illnesses are involved, if the services are related to an accident or if the member has other coverage and, if so, the identity of the other carrier or Plan.
- The Member Provider cannot require any member (before or after rendering a service) to pay any amount in excess of any deductible, coinsurance, copayments and amounts for noncovered services. The Member Provider shall look only to plan for payment of covered services for hospital services except for the deductible, coinsurance, copayments and amounts for noncovered services. The Member Provider cannot bill the member in excess of the reimbursement amount (allowable charge). For additional billing and reimbursement details for members with Consumer Directed Health Plans, please see the Network Overview section of this manual.
- Louisiana Blue will inform the Member Provider of services not included as covered services under the various Member Contracts/Certificates. The plan will also identify the amounts for these services that the Member Provider can collect from the member. However, the Member Provider must include all such charges on the claim submitted.
- The Member Provider cannot bill members for services which Louisiana Blue has determined to be not medically necessary, experimental or investigational, unless the Member Provider has notified the member in advance in writing that certain not medically necessary, experimental or investigational services will be the member's responsibility. Generic or all-encompassing notifications will not be deemed to meet the specific notification requirement mentioned above.
- Member Providers should submit the appropriate NPI number in Block 56 on the UB-04 claim form to ensure payment is made accurately and on time.

When Filing Claims on the CMS-1500 Form

- Claims should include all services rendered during the visit. Our reimbursement allowable for the E&M service includes the components for physician work, practice expense and malpractice insurance. No additional room usage charge should be billed by any party, since the practice expense component includes overhead expenses and is an integral part in the E&M or procedure allowable charge. This methodology applies to hospital owned and physician owned practices and helps ensure that contractual benefits for our members are correctly applied to claims.

TIMELY FILING

Note: Not all member contracts/certificates follow the 15-month claims filing limit. Always verify the member's benefits, including timely filing standards, through iLinkBlue.

All inpatient and outpatient claims must be filed within 15 months, or length of time stated in the member's contract, of the date of service. Claims received after 15 months, or length of time stated in the member's contract, will be denied and the member should be held harmless for these amounts.

There may be times when Louisiana Blue must request providers to refund payments previously made to them. When refunds are necessary, Louisiana Blue or its agent notifies the provider within 15 months of payment of the claim in question. The notification letter explains that Louisiana Blue or its agent will deduct the amount owed from future Payment Registers/Remittance Advices unless the provider contacts us within 30 days.

If Louisiana Blue returns a claim or part of a claim for additional information, providers must resubmit it within 90 days or before the timely filing period expires, whichever is later.

If Louisiana Blue has made any omissions or underpayments, Louisiana Blue will make payment for such errors as soon as they are discovered or within 30 days of written notice from the Member Provider regarding the error. Recoveries and payments for omissions and underpayments shall be initiated within 15 months of the claim's last date of payment or adjustment. In accordance with the Member Provider Agreement, Louisiana Blue and the Member Provider agree to hold each other and the member harmless for underpayments or overpayments discovered after 15 months from the date of payment.

Louisiana Blue FEP Preferred Provider claims must be filed within 15 months from date of service. Members/Non-preferred providers have no later than December 31 of the year following the year in which the services were provided.

Louisiana Blue claims for OGB members must be filed within 12 months of the date of service. Claims reviews including refunds and recoupments must be requested within 18 months of the receipt date of the original claim. OGB claims are not subject to late payment interest penalties.

NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the adoption of a standard unique identifier for healthcare providers. CMS has assigned national provider identifiers (NPIs) to comply with this requirement. NPIs are issued by the National Plan and Provider Enumeration System (NPPES). This one unique number is to be used when filing claims with Louisiana Blue as well as with federal and state agencies, thus eliminating the need for you to use different identification numbers for each agency or health plan.

To comply with the legislation mentioned above, all covered entities must use their NPI and corresponding taxonomy code, where applicable, when filing claims. All providers who are being credentialed or who are undergoing recredentialing, regardless of network participation, must include their NPI(s) on their application. Claims processing cannot be guaranteed unless you notify Louisiana Blue of your NPI(s) prior to filing claims using your NPI(s).

Notifying Louisiana Blue of Your NPI

Once you have been assigned an NPI, please notify us as soon as possible. To do so, you may use one of the following ways:

1. Include it on your credentialing or recredentialing packet.
2. Include it on the online National Provider Identifier (NPI) Change Form located in the "Resources" section on the Provider page.

Filing Claims with NPIs

Your NPI is used for claims processing and internal reporting. Claim payments are reported to the Internal Revenue Service (IRS) using your tax identification number (TIN). To appropriately indicate your NPI and TIN on UB-04 and CMS-1500 claim forms, follow the corresponding instructions for each form included in this manual. Remember, claims processing cannot be guaranteed if you have not notified Louisiana Blue of your NPI, by using one of the methods above, prior to filing claims. See the first part of this section for more details on how to submit claims to Louisiana Blue.

For more information, including **who should apply** for an NPI and **how to obtain** your NPI, visit our website or CMS site. If you have any questions about the NPI relating to your Louisiana Blue participation, please contact Provider Credentialing & Data Management.

Ordering/Referring Physician

The ordering/referring provider's first name, last name and NPI are required on all applicable claims filed with Louisiana Blue. Claims received without the ordering/referring provider's information will be returned and the claim must be refiled with the requested information.

Please enter the ordering/referring provider's information for paper and electronic claims as indicated below.

Paper Claims:

- CMS-1500 Health Insurance Claim Form: Block 17B

Electronic 837P, Professional Claims:

- Referring Provider - Claim Level: 2310A loop, NM1 Segment
- Referring Provider - Line Level: 2420F loop, NM1 Segment
- Ordering Provider - Line Level: 2420E loop, NM1 Segment

MEDICAL CODE EDITING TOOL ON ILINKBLUE

On iLinkBlue you can find the claims-editing software (CES) system tool under the "Claims" menu option. This is a code-auditing reference tool designed to help providers calculate claim edit outcomes for both professional and outpatient facility claims. View our *iLinkBlue User Guide* for more information on researching code combinations in the CES system tool. It is available on our Provider Page at www.lablue.com/providers >Resources >Manuals.

Note: The CES tool in iLinkBlue is not a pricing or claims processing tool. It is a research tool designed to evaluate code combinations in the Louisiana Blue claims-editing system.

ELECTRONIC PAYMENT REGISTER/REMITTANCE ADVICE (HIPAA 835 TRANSACTION)

Providers, who submit their claims electronically, can receive an electronic file containing their Weekly Provider Electronic Remittance Advice/Payment Register. The provider's software system can be programmed so that the ERA can be uploaded into an automated posting system, thus eliminating a number of manual procedures. The ERA is available Monday mornings, allowing providers to begin posting payments as soon as possible.

For more information, please contact our EDI Services.