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 (Louisiana Blue) 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.

UB-04 CLAIM FILING GUIDELINES

Louisiana Blue scans all paper claims to eliminate the need to manually enter the claims data into our system. Please follow the guidelines below to ensure that your claims are scanned properly, which will allow you to benefit from faster, more accurate claims processing:

- Louisiana Blue does not accept black and white hardcopy claim forms. Do not submit black and white copies, as data recognition can be affected and may delay the processing of claim payments. Black and white claims are less legible after they are scanned.
- Laser printed claims produce the best scanning results. If you use a dot-matrix printer, please use a standard 10-or 12-font ribbon when the type begins to fade. Do not print from an older dot-matrix printer; it may not be captured.

- Use claim forms that are printed on good quality paper. When the paper is too thin, the claim cannot be scanned properly.
- If you are not purchasing original U.S. Centers for Medicare & Medicaid Services (CMS) forms and instead print them locally, please ensure the margins are aligned exactly as an original CMS form. Otherwise, it will prevent the scanning equipment from extracting the data due to not being aligned as formatted under the CMS claim form specifications.
- Type or computer print all information within the appropriate blocks on the claim form. Information should not overlap from one block into another. Do not print claim data out of the designated field; it may not be captured.
- Do not use any stamps or stickers on your claim forms. The scanning equipment has a lamp that distorts stamps with black ink and completely removes any information with red ink. Therefore, stamps with pertinent information in red ink, such as "Benefits Assigned" or "Corrected Copy," will be lost if the claim is scanned.
- Use red drop on UB-04 paper forms only.
- Replacement/corrected claims require a Type of Bill with a Frequency Code "7" (field 4) and claim number in the Document Control Number (field 64).
- Enter all required data.
- All patient details are required (member ID number with prefix, last name, first name, and date of birth).
- Separate the subscriber/patient last name and first name with a comma.
- Ensure the use of proper coding (ICD-10 HIPAA codes, dates of service, and correcting a prior claim).
- Use standard fonts and sizes.
- Do not include handwriting anywhere on the claim form

For more instruction on completing UB-04 claim form fields, see the Appendix II Forms section of this manual.

Correcting Paper UB-04 Claims

- In Box/Field 4 (Type of Bill), enter 0117 (the "Replace" bill type). This will notify us that this is a corrected or replacement claim, and the claims examiners will not deny it as a duplicate claim. Use Form Locator 4, this regardless of which Priority Health plan covers the patient.
- In Box/Field 64 (Document Control Number), enter the original claim number. This will notify us of what claim is being corrected or replaced.
- In Box/Field 80, add a note to indicate the reason for the resubmission. Examples: Changed CPT, added modifier, corrected EOB, etc.

- If you are adding or changing clinical information on the claim, attach documentation.
- Mail the corrected claim to the appropriate processing address. You don't need to call or email us to alert us to your correction.

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. As applicable by line of business, recoveries and payments for omissions and underpayments shall be initiated within 12 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 12 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 received after 12 months will be denied for timely filing and the OGB member and Louisiana Blue should be held harmless. Claims reviews including refunds and recoupments must be requested within 12 months of the claim's last date of payment or adjustment.

NATIONAL PROVIDER IDENTIFIER (NPI)

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 an NPI Change

If your NPI changes, please notify Louisiana Blue as soon as possible. To do so, you may use the 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 Louisiana Blue Electronic Data Interchange (EDI) Services.