

Chapter 7. Billing and Claims Processing

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7.1 Electronic Claims Submission

7.1.1 How it Works

Mountain State strongly encourages providers to submit claims electronically. Instead of printing, bundling and sending paper claims through the mail, a provider can simply enter and store claims data in an electronic information system/computer. Then, as often as necessary, claim information can be transmitted by the provider or his/her chosen electronic billing vendor to Mountain State.

The required components for electronic claims submission are an information system/computer, an internet connection, and an appropriate software package.

7.1.2 Advantages

Some of the major benefits of electronic claims submission are:

- You save money on forms and postage.
 - You save time. Paper claims can take 2-3 days to reach us through the postal system; once the claim is received, it must be scanned into our system and then hand keyed. Key punch errors can occur.
 - Electronic claims process faster than paper claims, generally 7-14 days compared to 21-27 days.
 - Claims can be submitted 24 hours a day, 7 days a week.
 - Up front edits notify you (generally within 24 hours) if a claim was not accepted into our system. This allows you or your vendor to correct the error and resubmit the claim electronically.
 - Reports are generated to show you what claims were accepted into our system.
 - You can receive your remittance advice electronically.
 - You can have your check electronically deposited into your bank account.
-

7.1.3 How to Initiate

To get started or for more information, contact Mountain State Electronic Data Exchange (EDI) Operations at:

EDI Operations
Mountain State Blue Cross Blue Shield
P. O. Box 1948
Parkersburg, WV 26102-1948
Telephone: 1-800-344-5514, ext. 47728 or
(304) 424-7728
Fax: (304) 424-9810
Email: msemc@msbcbs.com

You may also contact your External Provider Relations Representative.

Detailed information and specifications are contained in the *Mountain State Provider EDI Reference Guide*, which can be accessed on the Mountain State website at www.msbcbs.com. Click on the Provider drop down menu then select MountainLink™ EDI.

Mountain State's EDI system supports electronic transactions adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires that procedures be established to secure access to data. Mountain State has a process to establish a Trading Partner relationship with providers who wish to submit claims electronically. A "Trading Partner" is any customer (e.g. provider, billing service) that transmits to or receives electronic data from Mountain State.

This process includes completing an *EDI Transaction Application* and executing an *EDI Trading Partner Agreement*. Once the agreement is received, the provider will be sent a logon ID and password combination for use when accessing Mountain State's EDI system. Mountain State requires testing of potential Trading Partners for each transaction included on the EDI transaction application. For detailed information and instructions please see Chapter 5 of the *Provider EDI Reference Guide*.

After sign-up, a provider should have its Trading Partner number and logon ID available whenever contacting the Mountain State EDI Operations Office to facilitate faster handling of your questions.

The *EDI Transaction Application* and *EDI Trading Partner Agreement* are available on the Mountain State website in the same location as the *EDI Reference Guide*.

The Mountain State EDI Operations Office can provide you with a list of software vendors, clearinghouses and billing services that are already HIPAA transaction-ready with Mountain State.

7.1.4 Transactions Available

As mandated by HIPAA, electronic claims are submitted to Mountain State using either the 837 Professional (837P) or 837 Institutional (837I) health care claim transaction. Upon receipt of the 837 transaction, there are several acknowledgement transactions you can choose for tracking electronic claim submissions and payment, depending on the capabilities of your software. These include:

- **997 Functional Acknowledgement.** This transaction is available the same day you transmit your claims. The benefit of this transaction is that it provides the ability to confirm that your electronic claim file was either accepted or rejected by Mountain State EDI Operations.
- **277 Claim Acknowledgement.** This transaction is available approximately 24 hours after the 997 Functional Acknowledgement report is accepted. The 277 Claim Acknowledgement indicates whether claims were accepted for processing. For those claims not accepted, the transaction provides instructions for the submitter to correct and resubmit the claims. For submitters that are not able to interpret the 277 Claim Acknowledgement Transaction, a text format Claim Acknowledgement Report has been developed.
- **835 Electronic Remittance Advice.** The 835 transaction is used to send an electronic Explanation of Benefits remittance advice from a payor to the Trading Partner. Mountain State's 835 transactions are created on a weekly basis to correspond with our weekly payment cycles. The 835 transaction files become available for retrieval by the provider from the Trading Partner. This transaction contains finalized claim payment information used for automated account posting.

A more complete listing of the provider EDI transactions Mountain State supports is provided below:

| Provider Transactions | |
|------------------------------|---|
| 270 Transaction | Eligibility/Benefit Inquiry |
| 271 Transaction | Eligibility or Benefit Information (response to 270) |
| 276 Transaction | Claim Status Request |
| 277 Transaction | Claim Status Notification (response to 276) |
| 278 Transaction | Two implementations of this transaction: <ul style="list-style-type: none"> • Services Review – Request for Review (Referral/Authorization Request) • Services Review – Response to Request to Review |
| 837 Transaction | Three implementations of this transaction: <ul style="list-style-type: none"> • Institutional • Professional • Dental |

| Provider Transactions | |
|------------------------------|--|
| | NOTE: Dental transactions (837Ds) for Mountain State products must be sent to Mountain State's dental associate, United Concordia Companies Inc. (UCCI). To receive authorization to submit transactions to UCCI, you must contact Dental Electronic Services at 1-800-633-5430. |
| 835 Transaction | Claim Payment/Advice (Electronic Remittance) |
| 277 Acknowledgement | Claim Acknowledgement (Replaces Submission Summary Report) |
| 997 Transaction | Functional Group Acknowledgement |

7.1.5 NAIC Codes

Accurate reporting of NAIC codes to identify the appropriate payor and to control routing is critical for electronic claims submitted to Mountain State EDI. For all Mountain State products use NAIC code 54828. For the FreedomBlue® Medicare Advantage PPO (a Highmark Health Insurance Company product), use NAIC code 71768.

7.1.6 NaviNetSM Internet Transactions

In addition to the EDI transactions described in this section, Mountain State offers network providers an expanded and enhanced set of transactions to enable them to communicate with the company via the internet through our provider "portal," NaviNetSM.

NaviNetSM is an internet-based system that makes information in Mountain State's systems available to providers in a real-time environment. Providers can verify eligibility and benefits, check on claim status, submit authorizations and perform many other functions that otherwise would require a telephone call, letter or fax.

For more information about NaviNetSM, see Chapter 1 of this *Provider Manual*.

7.1.7 Electronic Funds Transfer

Electronic Funds Transfer ("EFT") is the direct deposit of Mountain State payments to the provider's bank account. For more information on EFT eligibility and enrollment, providers should contact their External Provider Relations Representative or call the Office of Provider Relations at 1-800-798-7768 or 1-304-424-7795.

7.1.8 EDI System Operating Hours

Mountain State is available to handle EDI transactions 24 hours a day, 7 days a week, except during scheduled system maintenance periods.

Mountain State EDI Trading Partners should transmit any test data during the hours that Mountain State EDI Operations support is available. These hours are 8:00 a.m. to 4:00 p.m. ET, Monday through Friday.

7.2 Where To Submit Claims

Submit all paper claims to:

| |
|---|
| Mountain State Blue Cross Blue Shield P. O. Box 7026 Wheeling, WV 26003 |
|---|

Please submit all Blue Cross and Blue Shield claims to Mountain State at the above address for processing. If we cannot process the claims through the BlueCard Program, we will forward them to the member's home plan. For more information on BlueCard, see Section 7.6 of this *Provider Manual*.

7.3 Claim Forms / Coding / Modifiers

7.3.1 Forms

Physicians, other professional and allied health providers, and laboratories must submit claims on a CMS 1500 form (formerly HCFA 1500). Hospitals must use the current UB form. The type of form (either UB or CMS 1500) required for ancillary providers varies by provider type. A complete listing of the required forms by type of ancillary provider can be found in Section 5.2.1 of this *Provider Manual*.

In order for a claim to be considered clean and to avoid delay or rejection, claims must be completed in accordance with applicable instructions and contain all information requested in every field of the claim.

7.3.2 Coding

Claims should be submitted on the appropriate type of form using the most appropriate and current diagnosis (ICD-9-CM), AMA CPT procedure codes,

HCPCS codes for professional services, ASA procedure codes for anesthesia services, and UB-04 Revenue Codes to reflect the services provided.

7.3.3 Modifiers

Mountain State recognizes all CPT and HCPCS modifiers when used appropriately. All circumstances supporting the use of the modifier must be documented in the member's medical record.

Mountain State does not routinely require that medical records supporting use of a modifier be submitted along with the claim, except when Modifier 22 (unusual procedural services) is used. When Modifier 22 is used, the provider must submit supporting documentation with the claim that the service provided is greater than that usually required for the CPT procedure code billed.

Mountain State may identify other limited categories of claims for which it determines that routine submission of medical records with a claim is appropriate. Mountain State will post notice of any such requirement in the Provider section of our website, www.msbcbs.com, at least 60 days in advance of the change.

Our medical policies may address use of a particular modifier and any required record submission in connection with billing for the service or services addressed in the medical policy. Our medical policies are published on our website and may be searched by key word (e.g. anesthesia), type of service (e.g. radiology) or through an alphabetical index. For more information see Section 6.6 of this *Provider Manual*.

Mountain State may require the submission of medical records before or after payment of claims for the purpose of investigating potentially fraudulent, excessive, abusive or other inappropriate billing practices. We reserve the right to perform retrospective audits to verify the appropriate use of modifiers (e.g. Modifier 25).

Use of a particular modifier will not automatically override all clinical edits integrated into the claims payment system and will not supersede benefit limits or exclusions. If payment for a service submitted with a modifier is denied or reduced and the provider disagrees with the payment determination, then the provider should submit supporting documentation from the medical record together with any appeal.

Nothing in this section is intended to limit Mountain State's right to require or request the submission of medical records in connection with precertification or prior authorization of services. (See Chapter 6 of this *Provider Manual*.)

7.4 Provider ID / National Provider Identifier

The National Provider Identifier (“NPI”) is a Health Insurance Portability and Accountability Act (“HIPAA”) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses will use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. As of May 23, 2007 (May 23, 2008, for small health plans), the NPI must be used in lieu of legacy provider identifiers in the HIPAA standard transactions. Covered entities may invoke contingency plans after May 23, 2007, and information about contingency plans may be obtained by calling CMS or visiting the CMS web site as described below.

As outlined in the Federal Regulation, HIPAA, covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

Healthcare providers who bill for services probably need an NPI. If one bills Medicare for services, he/she definitely needs an NPI. Getting an NPI is easy and it is free. The first step is to get an NPI. Delays can risk cash flow, and jeopardize patient services. Call 1-800-465-3203 to learn more, or visit CMS’ website at www.cms.hhs.gov/NationalProvIdentStand/03_apply.asp

NPI Frequently Asked Questions (“FAQs”) and other valuable NPI resources are available for perusal and downloading on the CMS web site at www.cms.hhs.gov/NationalProvIdentStand/.

7.5 Timely Filing

7.5.1 When We are Primary

When Mountain State is the primary payor, a provider must submit a claim within 12 months after the date the service is provided or the date the member is discharged from the hospital or other facility, unless the member’s policy provides otherwise. Mountain State will identify on its website (www.msbcbs.com) groups with timely filing policies that differ from the 12-month filing period. Claims submitted beyond these timelines will be denied.

If a provider initially submits a claim within the timely filing period and Mountain State requests additional information, then the provider must submit the requested information within 30 days, or before expiration of the timely filing period, whichever is longer. If the requested information is not submitted timely, the claim will be denied and both Mountain State and the member are held harmless, except for any applicable copays, coinsurance or deductibles.

Late charges must be submitted within the timely filing period or they will be denied.

If a claim is denied for failure to meet timely filing requirements, the provider must hold both Mountain State and the member harmless.

7.5.2 When We are Secondary

When Mountain State is a secondary payor, a provider must submit a claim within 12 months after the date the primary payor adjudicated the claim, unless the member's policy provides for a different period. The provider must attach to the claim an Explanation of Benefits documenting the date the primary payor adjudicated the claim. Secondary claims not submitted within the timely filing period will be denied and both Mountain State and the member held harmless.

When it is known or there is reason to believe that other coverage exists, claims are not paid until the other carrier's liability has been investigated. Mountain State may send a letter/questionnaire to the covered person. If the covered person responds to the letter/questionnaire indicating that he/she is covered by additional policies, the records are marked to indicate that other carrier information is required in order to complete claims processing when the other carrier's policy is primary. If the covered person does not respond promptly to Mountain State's request for information, Mountain State will deny claim payment using a remark code indicating the covered person is responsible. (FEP claims are not denied but are pended until a response is received from the covered person. Mountain State will not provide benefits for these FEP claims until a response is received.) The provider may seek reimbursement from the covered person.

7.5.3 Special Circumstances for Terminated Self-Funded Accounts

Upon termination of a self-funded group, Mountain State will continue to process claims for a period of time as specified in the terminated self-funded account's contract. This is otherwise referred to as a "run-out period." Often the run-out period is less than 12 months, and claims received after this period will be denied.

7.5.4 Investigation of Other Coverage

If we have reason to believe that a member might have other coverage, we may pend a claim to allow us to investigate whether such coverage exists and, if so, determine which coverage is primary. Mountain State may send a questionnaire to the member inquiring about other coverage. If the member does not respond within the requested timeframe, Mountain State may deny the claim and indicate that the member is responsible for payment.

7.6 BlueCard® Program

7.6.1 What is BlueCard®?

BlueCard® is a national program that enables members of one Blue Cross or Blue Shield plan to obtain health benefits while traveling or living in another Blue plan's service area. The program links network health care providers with the independent Blue Cross and Blue Shield plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

As a network provider with Mountain State, BlueCard lets you submit claims for patients who are members of other Blue plans, domestic and international, to Mountain State as your local Blue plan. Mountain State serves as your primary point of contact for claims payment and other claims-related questions.

7.6.2 BlueCard® Provider Manual

A detailed *BlueCard® Program Provider Manual* can be accessed on the Mountain State website at www.msbcbs.com. The manual offers helpful information about:

- Identifying members;
- Verifying eligibility;
- Obtaining precertification or preauthorization;
- Filing claims; and
- Who to contact with questions.

Because of the strong likelihood that you will provide services to members of other Blue plans, you are encouraged to familiarize yourself with the *BlueCard® Program Provider Manual* and the rules governing this program.

If you have questions about the BlueCard® program, please contact your External Provider Relations Representative or call the Office of Provider Relations at 1-800-798-7768 or 1-304-424-7795. For questions related to specific claims, please contact Mountain State Customer Service at 1-800-543-7822.

7.6.3 Border County Providers

BlueCard® claim submission rules are different for Mountain State network providers located in counties contiguous to West Virginia (other than Washington County, Ohio, which is part of Mountain State's service area). These providers generally must submit claims for members of Blue plans other than Mountain State to the local Blue plan for the county in which the provider is located. Claims for Mountain State members should always be submitted to Mountain State. Please consult the *BlueCard® Program Provider Manual* for more specific information.

7.7 Claim Inquiries

For questions about a particular claim, providers should contact Mountain State Customer Service at the appropriate number listed below.

| | |
|---------------------------------------|----------------------------------|
| Claims Customer Service – Parkersburg | (888) 809-9121 or (304) 424-7701 |
| Claims Customer Service – Wheeling | (800) 654-5028 or (304) 234-7012 |
| FEP Customer Service – Parkersburg | (800) 535-5266 or (304) 424-7792 |
| FreedomBlue® Customer Service | (888) 459-4020 |

Normal business hours are **8 a.m. to 4 p.m.**, Monday through Friday for local and FEP business.

When contacting Customer Service, please have the following information available:

- Member's name;
- ID number;
- Patient's name;
- Provider ID number;
- Date of service; and
- Provider's charge.

Written inquiries should be sent to:

| |
|---|
| Mountain State Blue Cross Blue Shield P. O. Box 7026 Wheeling, WV 26003 |
|---|

Providers may also inquire about the status of a claim electronically via NaviNetSM or EDI transaction. See Section 7.1 of this *Provider Manual*.

7.8 Adjustment of Incorrect Payments

A demand for repayment or an adjustment of an overpayment will generally be initiated by Mountain State within two years after the date of claim payment. This two-year limit does not apply to claims that:

- Were submitted fraudulently;
- Contain material misrepresentations;
- Represent a pattern of abuse or intentional misconduct;
- Are for self-funded plans where Mountain State acts as a third party administrator;
- Involve other payor or party liability (e.g. Workers' Compensation exclusions, subrogation);
- Are subject to a different recovery period under federal or state law or the member's contract;
- Involve a good faith dispute about the legitimacy of the amount of the claim (e.g. disputed audit findings during the resolution process);
- Where Mountain State's failure to comply with the time limit is caused in material part by the person submitting the claim or Mountain State's compliance is rendered impossible due to matters beyond its reasonable control (e.g. fire, pandemic flu); or
- Where the provider is obligated by law or other reason to return payment to Mountain State or a Mountain State member.

The two-year limit also does not apply to certain retroactive denials for which recovery is limited to one year under Section 7.11.7 of the *Provider Manual*.

7.9 Appeals

For challenges to appeals of medical payment adequacy and amount, see Section 6.4 of this *Provider Manual*.

7.10 Self-Funded Accounts

Mountain State acts *only* as a third party administrator for a self-funded benefit plan (i.e. the benefits are not insured by us and our services are administrative only). We shall not be required to pay a provider's claim for services rendered to a member of the self-funded plan unless and until the self-funded plan pays or reimburses Mountain State for the amount of the claim and the administrative cost to process and pay the claim. Mountain State does not insure, underwrite or guarantee the responsibility or liability of any self-funded plan to provide benefits or to make or administer payments.

If a self-funded plan fails to provide payment or reimbursement to Mountain State to fund claims (whether such claims have been paid already by Mountain State or not), then a provider shall not hold Mountain State liable, but must look to the self-funded plan or the patient for payment. Mountain State may demand the return of any payment to the provider, or may set off against amounts owed to the provider, for any claims for which a self-funded plan fails to make payment or reimbursement to Mountain State.

Member ID cards identify members of self-funded accounts. Providers may contact Mountain State Customer Service at the telephone number on the back of the card to inquire about the current eligibility status of the member, or contact the Office of Provider Relations at 1-800-798-7768 with questions regarding the current funding status of a self-funded account.

7.11 West Virginia Prompt Pay Act

7.11.1 Applicability

The Ethics and Fairness In Insurer Business Practices Act, W.Va. Code §33-45-1 et seq., commonly referred to as the "Prompt Pay Act" ("the Act"), applies to health insurance contracts insured by Mountain State, with certain exceptions. For claims subject to the Act, Mountain State adheres to the standards for processing and payment of claims established by the Act. These standards are summarized in this Section 7.11 or are addressed in other parts of this *Provider Manual*.

The Act does not apply:

- To services furnished by providers not contracted with Mountain State;
- To providers outside of West Virginia;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, Medicare Supplemental and PEIA;

- To most self-funded plans where Mountain State acts as a third party administrator;
 - To BlueCard® claims;
 - To claims that are not covered under the terms of the applicable health plan (e.g. Workers' Compensation exclusions);
 - When there is a good faith dispute about the legitimacy of the amount of the claim;
 - When there is a reasonable basis, supported by specific information, that a claim was submitted fraudulently or with material misrepresentation; or
 - Where Mountain State's failure to comply is caused in material part by the person submitting the claim or Mountain State's compliance is rendered impossible due to matters beyond our reasonable control.
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7.11.2 Payment of Clean Claims

Mountain State will generally either pay or deny a clean claim subject to the Act within 40 days of receipt if submitted manually, or 30 days if submitted electronically, except in the following circumstances:

- Another payor or party is responsible for the claim;
- We are coordinating benefits with another payor;
- The provider has already been paid for the claim;
- The claim was submitted fraudulently; or
- There was a material misrepresentation in the claim.

A "clean claim" means a claim: (1) that has no material defect or impropriety, including all reasonably required information and substantiating documentation to determine eligibility or to adjudicate the claim; or (2) with respect to which Mountain State has not timely notified the person submitting the claim of any such defect or impropriety in accordance with Section 7.11.4 below.

7.11.3 Record of Claim Receipt

Mountain State maintains a written or electronic record of the date of receipt of a claim. The person submitting the claim may inspect the record on request and may rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If we fail to maintain such a record, the claim will be considered received three business days after it was submitted, based upon the written or electronic record of the date of submittal by the person submitting the claim.

7.11.4 Requests for Additional Information

For claims subject to the Act, if Mountain State reasonably believes that information or documentation is required to process a claim or determine if it is a clean claim, then we will:

- Request such information within 30 days after receipt of the claim;
- Use all reasonable efforts to ask for all desired information in one request;
- If necessary, make only one additional request for information;
- Make such additional request within 15 days after receiving the information from the first request; or
- Make the second request only if the information could not have been reasonably identified at the time of the original request or if there was a material failure to provide the information initially requested.

Upon receipt of the information requested, we will either pay or deny the claim within 30 days.

We cannot refuse to pay a claim for covered benefits if we fail to request needed information within 30 days of receipt of the claim, unless this failure was caused in material part by the person submitting the claim. Mountain State is not precluded from imposing a retroactive denial of payment of such a claim, unless this denial would be in conflict with the Act's standards on retroactive denials.

7.11.5 Interest

For clean claims subject to the Act that are not paid within 40 days, Mountain State will pay interest, at the rate of 10% per year, on clean claims, accruing after the 40th day. We will provide an explanation of the interest assessed at the time the claim is paid.

7.11.6 Limitation on Denial of Claims Where Authorization, Eligibility and Coverage Verified

Under the terms of its health plan contracts, Mountain State will reimburse for a health care service only if:

- The service is a covered service under the member's plan;
- The member is eligible on the date of service;
- The service is medically necessary; and
- Another party or payor is not responsible for payment.

If Mountain State advises a provider or member in advance of the provision of a service that: (1) the service is covered under the member's plan; (2) the member is eligible; AND (3) via pre-certification or pre-authorization, the service is medically necessary, then we will pay a clean claim under the Act for the service unless:

- The claim documentation clearly fails to support the claim as originally pre-certified or pre-authorized;
- Another payor or party is responsible for the payment;
- The provider has already been paid for the service;
- The claim was submitted fraudulently or the pre-certification or pre-authorization was based in whole or material part on erroneous information provided by the provider, member or other person not related to Mountain State;
- The patient was not eligible on the date of service and Mountain State did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status;
- There is a dispute regarding the amount of the charges submitted; or
- The service provided was not a covered service and Mountain State did not know, and with the exercise of reasonable care could not have known, at the time of the verification that the service was not covered.

7.11.7 Retroactive Denials

Under the Act, Mountain State may retroactively deny an entire previously paid claim insured by Mountain State for a period of one year from the date the claim was originally paid. There is no time limit for retroactively denying a claim for the exceptions identified in Section 7.8 of this *Provider Manual*. In addition, the Act and its one-year time limit does not apply:

- To services furnished by providers not contracted with Mountain State;
- To contracted providers outside of West Virginia;
- To government programs such as the Federal Employee Health Benefit Program, Medicare Advantage, Medicare Supplemental and PEIA;
- To BlueCard claims; or
- To claims that are not covered under the terms of the applicable health plan (e.g. Workers' Compensation exclusions).

The two-year limit will apply to the above situations unless otherwise excepted under Section 7.8 of this *Provider Manual*.

Provider Recovery Process. Upon receipt of a retroactive denial under this Section 7.11, the provider has 40 days to either: (1) notify Mountain State of the

provider's intent to reimburse the plan; or (2) request a written explanation of the reason for the denial.

Upon receipt of an explanation, a provider must: (1) reimburse Mountain State within 30 days; or (2) provide written notice that the provider disputes the denial. The provider should state reasons for disputing the denial and include any supporting information or documentation.

Mountain State will notify the provider of its final decision within 30 days after receipt of the provider's notice of dispute. If the retroactive denial is upheld, the provider must pay the amount due within 30 days or the amount will be offset against future payments.
