Select HMO Claims Submission

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Select HMO Claims Submission

Introduction

This section provides general billing guidelines and claim submission requirements. To assist the biller in reducing the number of returned claims, the manual identifies the more common situations that result in processing delays due to returned or rejected claims. Also covered is an overview of electronic billing and whom to contact for information on Electronic Data Interchange (EDI) products and services.

Information for Contracting Providers – Claims Settlement Practices

As required by Assembly Bill 1455, the California Department of Managed Health Care has set forth regulation establishing certain claim settlement practices and the process for resolving provider disputes for managed care products. To the extent required by the Department of Managed Health Care, the Knox-Keene Act or accompanying regulations, the following is intended to inform you of your rights, responsibilities and related procedures, as they relate to claim settlement practices for commercial HMO, POS and, where applicable, PPO products where Anthem Blue Cross (Anthem) is delegated to perform claims payment. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in Sections 1300.71 and 1300.71.38 of *Title 28* of the *California Code of Regulations*.

Claim Submission Instructions

1. **Sending Claims to Anthem.** Send all hard copy claims to:

   Anthem Blue Cross
   P.O. Box 60007
   Los Angeles, CA 90060-0007

2. **Calling Anthem Regarding Claims.** Call the Provider Care department at **800- 677-6669**.

3. **Claim Submission Requirements.** A list of commonly required claim attachments, supporting information, and documentation required by Anthem may be found in the various Anthem operations manuals.

4. **Center of Medical Excellence.** Refer to the Anthem Center of Medical Excellence (CME) Transplant Claim Billing Guidelines and Claim Submission Requirements *Section IV* of the *CME Operations Manual* in the *Exhibits* section of the provider operations manual.

5. **Claim Receipt Verification.** To verify receipt of your claim, log on to ProviderAccess® at **https://provider2.anthem.com/wps/portal/ebpmybcc**. Your Explanation of Benefits (EOB) or Remittance Advice (RA) will verify receipt of your claim as well.

Claim Overpayments

1. **Notice of Overpayment of a Claim.** If Anthem determines that it has overpaid a claim, Anthem will notify the provider, in writing, through a separate notice identifying the claim, the name of the patient, the date of service(s), and a clear explanation of the basis on which Anthem believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. **Contested Notice.** If the provider contests Anthem's notice of overpayment of a claim, the provider, within 30 working days of receipt of the notice of overpayment of a claim, must send written notice to Anthem stating the basis on which the provider believes that the claim was not overpaid. Anthem will process the contested notice in accordance with Anthem' contracted provider dispute resolution process, as described in the *Information for Contracting Providers - Provider Dispute Process* subsection of the *Physician Responsibilities* section in the provider operations manual.

3. **No Contest.** If the provider does not contest Anthem's notice of overpayment of a claim, the provider must reimburse Anthem within 30 working days of the provider's receipt of the notice of claim overpayment.

4. **Offsets to Payments.** If the provider does not reimburse Anthem within 30 working days of the provider's receipt of the notice of overpayment of a claim, then, pursuant to the *Select Network Participating Physician Agreement,* the provider authorizes Anthem to offset an uncontested notice of overpayment of a claim from the provider's current claim submission. Anthem may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse Anthem within the time frame set forth in **No Contest**, above, and (ii) Anthem's contract with the provider specifically authorizes Anthem to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims, pursuant to this section, Anthem will give the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

5. **Balance Billing Prohibition.** Except for applicable copayments and deductibles, a physician shall not invoice or balance bill a Anthem member for the difference between a physician's billed charges and the reimbursement paid by Anthem for any covered benefit.

General Guidelines

Anthem establishes and, from time to time, revises unit values based on observed charge patterns by Physician's Current Procedural Terminology (CPT) and CMS Common Procedure Coding System (HCPCS) Level II codes. The presence of a code in the current CPT, HCPCS, or other procedure manuals does not necessarily indicate Anthem allows the services. **Anthem retains discretion in the determination of payment structures**.

Anthem uses these guidelines for administrative purposes, such as claims processing and developing guidelines for Medical Review and Medical Policy.

The allowable charge for services will be calculated using the unit values as in effect at the time of service, multiplied by the applicable conversion factors.

The following are general claim submission guidelines:

1. **System Edits.** Edits are in place for both electronic and paper claims. Therefore, claims not submitted in accordance with requirements cannot be readily processed, and most of these will likely be returned.
2. **HCPCS and CPT Codes.** Current HCPCS and CPT Manuals must be used because many changes are made to these codes every year. Anthem uses only current HCPCS and CPT codes. For information about how to purchase current HCPC and CPT Manuals, see the *Billing References* subsection below.

3. **Reimbursement for HCPCS Level II Codes**

    a. **Pharmacy (including infusion therapy drugs).** Statewide maximum allowable changes are established by Anthem and takes into consideration claims and/or external data, including Average Wholesale Price (AWP).

    Self-injected drugs for home use and all oral prescription drugs dispensed in the physician office will be denied and the member may not be billed by the physician and/or other health care clinician. These drugs must be provided by a licensed pharmacy. Use the appropriate code that best describes the dosage being administered. To ensure appropriate allowances, include the units of occurrence in box 24G (Units-Days) of the *CMS-1500* form.

    b. **Injectable medications.** Injectable medications that are administered in the physician's office and /or other medical facility can be reimbursed when using the appropriate code that best describes the dosage being administered. To ensure appropriate allowances, include the units of occurrence in box 24G (Units-Days) of the *CMS-1500* form.

    c. **Durable Medical Equipment, Supplies (including, but not limited to, infusion therapy supplies), Prosthetics and Orthotics.** The maximum allowable will be determined by Anthem based on claims data and/or external data. The maximum allowable will be based on whether the equipment is new, used, or rented as identified by the HCPCS Level II code modifier. Anthem may designate certain items as "rental only" or "purchase only" or "rent to purchase." For "rent to purchase" items, the maximum allowable is the Anthem-determined purchase price; rental will not exceed the purchase price. Codes not identified by a modifier as "purchase" will be considered as rentals. DME equipment used in the physician's office is separately reimbursable.

d. **Other HCPCS Codes.** For other HCPCS codes, the maximum allowable will be determined by Anthem using claims data and/or external data.

4. **Split Year Claims.** For services that begin before December 31, but extend beyond December 31, split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and copayment maximums.

5. **Modifiers.** A modifier indicates that the procedure performed by the physician has been altered by some specific circumstance, but has not changed in its definition or code. The presence of a modifier in the current CPT, HCPCS or other procedure manuals does not necessarily indicate Anthem allows the services. Anthem retains discretion in the determination of payment structures.

   Modifiers may be billed in accordance with the CPT and HCPCS manual to indicate the following:

   - A service or procedure requiring a professional or technical component (Not all services are considered to have professional or technical components; some procedures are considered as professional only or global only)
   - A service or procedure performed by more than one physician and/or in more than one location
   - A service or procedure that increased or was reduced
   - A service or procedure rendered more than once
   - Partial procedure performed
   - Adjunctive services
   - Bilateral procedures
   - Unusual events occurred
   - When billing Modifier 22, the physician must include an operative report or medical records

   * Effective January 1, 2001, modifier 27 is no longer accepted for technical component; use "TC" to indicate the technical component. AMA has designated modifier 27 for Multiple Outpatient Hospital E/M Encounters on the same date.

   For more information about billing with modifiers, see *Modifier Reimbursement Guidelines* below.

6. **Cardiac Catheterization.** For cardiac catheterization codes, physicians are required to bill these services with the modifier 26 to reflect the professional service.

7. **Anesthesia Codes and Modifiers.** To be consistent with industry guidelines, Anthem changed its anesthesia service billing procedures to conform with the practice of using only current CPT codes 00100 through 01999 when billing for anesthesia administration. Anthem does not accept the practice of billing anesthesia services using surgical codes with a modifier 23 or 30.

In addition, when two or more surgical procedures are performed during the same operative session, only the anesthesia procedure with the higher base unit value is allowed for reimbursement.

8. **Anesthesia Time**. To more accurately calculate and reimburse physicians or other health professionals for anesthesia services, Anthem requires all anesthesia services to be billed using minutes.
9. **Unlisted Procedure or Service**. There may be services or procedures performed by physicians that are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, Anthem needs a description of the service to calculate the appropriate reimbursement, and medical records may be requested.
10. **CPT Code 99070.** CPT Code 99070 (supplies and materials provided by the physician over and above those usually included with the office visit or other services) is not accepted by Anthem. Physicians and other health professionals are to use HCPCS Level II codes, which give a detailed description of the service provided. Anthem will follow Medicare guidelines and cover surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be payable separately.
11. **Multiple Surgeries.** Multiple surgery claims are priced based on major and minor procedures. The surgical procedure with the highest Anthem unit value is considered the major procedure and is priced at 100 percent of the unit value. The minor surgeries have a lesser unit value and are reduced as follows:

Procedure Position	Allowance
Second Procedure	50 percent of unit value
Third Procedure	25 percent of unit value
Fourth Procedure	25 percent of unit value
Fifth Procedure	25 percent of unit value

Claims submitted with more than five surgeries are referred to Medical Review for pricing determination.

Effective December 15, 2006:

Multiple Surgery Reduction – Surgical procedures that can be billed with multiple units of occurrence will be subject to the same Multiple Surgery Reduction (MSR) rules as those billed on separate lines. We will update our payment system so that, regardless of whether these procedures are billed on one line or multiple lines, the MSR reimbursement rules will apply.

Incidental Services – There are a number of services that are being billed separately, but should be considered "incidental" when they are provided with another procedure. We have updated our payment system to identify these incidental codes.

12. **Laboratory Claims.** Physicians must supply laboratories with a diagnosis, correct patient information (including full name and date of birth), and appropriate billing information. This information is important to ensure that laboratories have the appropriate information to bill Anthem.

Common Reasons for Rejected and Returned Claims

Many of the claims returned for further information result from common billing errors. The following is a list of some of the more common situations.

1. **No Prior Authorization for services rendered.** For those services that require authorization, the authorization should be obtained prior to services being rendered.
2. **Alpha prefix on subscriber ID not provided.** The three-digit alpha prefix is critical for the proper identification and routing of all claims.
3. **Date of injury not provided.** When charges represent an injury diagnosis, provide a date of injury.
4. **Other Carrier Explanation of Benefits not provided.** When billing Anthem as a secondary payor, a copy of the primary carrier's explanation of benefits must be attached.
5. **Duplicate billings.** Overlapping dates of service for the same service(s) create a questionable duplicate bill.
6. **DSM-IV diagnosis coding denied.** ICD-9 codes should be used when billing diagnosis codes.
7. **ICD-9-CM Codes denied.** Claims that are coded with a preliminary, rather than a definitive diagnosis, are mailed back for the definitive diagnosis.
8. **Member ID number is incomplete.** Specifically in the case of (Federal Employee Program) FEP (except for Anthem Blue Cross HMO FEP), the alpha prefix is omitted in addition to other numeric digits. The FEP ID number starts with an alpha "R" and is followed by eight numeric digits. Supply the nine-digit ID number for all FEP submissions.
9. **Request for medical records.** When returning records to Anthem, it is imperative that the records are attached to the original mailback form and that the records are returned in the return envelope provided. Do not reattach a new copy of the claim. Do not combine other mailbacks in the same envelope since it is likely that the records will not arrive in the correct department.

10. **Unlisted HCPCS codes submitted without description.** A full description of unlisted HCPCS codes should be included on claims. When submitting claims electronically, enter the description in the REMARKS field.
11. **Unreasonable numbers submitted.** Unreasonable numbers, e.g., "999" in the UNITS field. Units greater than 999 should be indicated on the claim or in the remarks section if billing electronically.

Claim Follow-Up

Anthem will reconsider rejected or returned claims, on the physician's or health care professional's request. To request such a reconsideration, attach the *Claim Follow-Up Form* to the top of a copy of any applicable correspondence that was received from Anthem along with any other applicable documentation.

For more information concerning claims follow up, refer to the *Physician Responsibilities* section of the provider operations manual.

The *Claim Follow-Up Form* streamlines the process for physicians and other health care professionals seeking re-evaluation of their rejected claims. The form highlights the key claims information necessary for Anthem's reconsideration. The form should be used for all claims needing follow up.

Providers often resubmit copies of claims that have been rejected, denied or deemed incomplete, along with the additional information requested by Anthem. Under review, these copies are regularly treated as duplicate submissions.

Use of this form will help providers avoid this pitfall by providing the follow-up claims information only. The *Claim Follow-Up Form* identifies the common claim submission errors in order to minimize the need for explanation. The form will minimize your administrative burden and will help get the claim reprocessed as expeditiously as possible.

After completing the form, place it on top of all documentation and mail it to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Electronic Claims Submission

Introduction

Anthem continues to look for ways to reduce administrative costs that can translate to savings for our members. One element driving these costs up is the submission and processing of paper claims. With the increased acceptance of computer technology in general, and electronic billing technology in particular, Anthem strongly promotes using this technology for claims submission. In addition to providing the capability to more easily measure the quality of claims processing and production,

electronic claims submission leads to increased productivity, efficiency, and service. For more information about EDI, call **800- 227-3983**.

What Is EDI?

Electronic Data Interchange (EDI) is the computer-to-computer exchange of common business transactions over telephone lines using a standard electronic format.

EDI can be compared to an electronic postal service that allows physicians, other health professionals, and payors to exchange vital information.

How It Works

A computer, modem and telephone line enable you to send and receive vital information such as claims, encounters, eligibility and claim-status transactions, and electronic remittance advices (ERAs). Anthem partners with many software vendors, clearinghouses and billing services that collect the data you submit and send it to us electronically. Most of these partners are also linked to hundreds of health care EDI networks.

Benefits To You

One-Address Billing. With electronically submitted claims, all claims are sent to one destination, and Anthem automatically routes your claim to the proper processing site.

Fewer Rejected Claims. Claims are processed quickly and accurately with fewer claim rejects because the system provides front-end editing and does not accept common errors or omission of mandatory data. This means claims are virtually error free when they enter the Anthem processing system, which results in faster payment turnaround.

Savings. By reducing the cost of purchasing *CMS-1500* forms, mailing envelopes, postage stamps and printing costs, you can easily recognize the savings. Your billing staff will also spend less time on claim payment follow-up because priority processing is given to electronic claims.

Acceptance/Rejection Audit Trails. You receive validation of claims from Anthem, confirming that your electronic claim file was received. It also identifies those claims that did not pass our claim edit process. These claims must be corrected immediately and resubmitted electronically.

Getting Started

If you have any questions or problems, call Anthem's EDI Solutions at **800-227-3983**. Our representatives are very knowledgeable and can assist you with all your questions regarding electronic billing and other electronic services that are available.

BlueCard Claims

Submit ALL your BlueCard claims for out-of-state patients directly to Anthem. Submit your hard copy BlueCard claims to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, California 90060-0007

When submitting your claims electronically for Blue Plan members, include the patient's complete identification number including the three-digit alpha prefix. Include the group number in the "Group Number" field. If the group number is not listed, leave the group number blank or use 999999. This ensures that your claims will be routed correctly and properly processed and not denied in error. [Jeffrey Miller]

Hard Copy Billing

Participating professional physicians and other health professionals that are not set up to process claims electronically are required to submit all hard copy claims on the *CMS-1500* claim form (with scannable "red dropout ink"). All applicable data element blocks must be complete. If the form is incomplete, it is returned for additional information needed for processing.

Provider License

Anthem requires physicians and other health professionals to include their state license number and the ZIP Code for their practice (the location where services are rendered) when submitting claims. All professional claims submitted to Anthem must include this information consistent with Section 6.9 of the *Select Network Participating Physician Agreement*. If the Tax ID number is that of a medical group, the rendering physician's name and license number must also appear on the claim.

All license numbers are validated against the license number file from the State Board of Consumer Affairs.

On the *CMS-1500* form, the license number is entered in box number 19 and the ZIP Code in box number 32. The state license number and practice ZIP Code requirements apply to optical character recognition (OCR) scannable paper claims, non-scannable *CMS-1500* paper claims, and electronically submitted claims.

Claims submitted without a state license number may be returned or may have processing delayed.

The following providers are not required to provide Blue Cross with a state license number (exempt providers must include practicing ZIP Code):

1. Air ambulance
2. Blood bank
3. Christian Science nurse
4. Christian Science practitioner
5. Donor bank
6. Group ambulance

7. Independent laboratory
8. Medical vendor (DME)
9. MRI
10. Occupational therapy
11. Optician
12. Orthotics/prosthetics
13. Pharmacy
14. Portable X-ray
15. Anthem PPO clinical laboratory
16. Anthem PPO diagnostic imaging/MRI

Claim Submission Filing Limits

Physicians must submit claims to Anthem within 12 months from the date of service or Anthem may refuse payment. The 12-month claim filing also applies to adjustments when Anthem is the primary carrier. For claims that involve coordinating benefits with another carrier or Medicare, the date of the other carrier's *Explanation of Benefits* (EOB) or Medicare's *Explanation of Benefits* (EOMB) is used for determining the eligible submission period.

Claims that are filed beyond the timely filing period will be denied accordingly. The patient is not responsible for this amount. If it is believed that the claim was filed within the contracted timely filing guidelines, evidence of timely filing attached to the Anthem mailback or denial EOB should be submitted in a timely manner for consideration. DO NOT RESUBMIT THE ORIGINAL CLAIM.

Anthem may, for example, accept the following as evidence of timely **electronic** submission:

- Clearinghouse report (e.g., NEIC) of acceptance by Anthem
- *Request for Additional Information* form (from Anthem)
- Anthem generated *Positive Acknowledgement Report* (Should you need your report recreated during the first 30 days after submission, please call **800-227- 3983**, option 1.)
- Claim denial letter or EOB from Anthem
- For EDI claims which could not be processed by Anthem:
    - Copy of Anthem's dated letter to provider requesting a resubmission, or
    - Anthem Batch Number for claims (or other identifying information) or error listing

Anthem may, for example, accept the following as evidence of timely **hard copy** submission:

- Computer-generated claim transaction history with the Anthem name from a billing system
    - If a locator code is used instead of the billing address, a list of locator codes/ corresponding addresses must be provided

  - Must include billing history and history of timely follow-up attempts made within contracted timely filing guidelines
- Dated request for additional information form (from Anthem)
- Claim denial letter or EOB from Anthem

Anthem accepts the following as proof of submission when initially **sent to another carrier**:

- Denial letter from other insurance carrier, dated and printed on letterhead; or
- Dated EOB from other insurance carrier.

Anthem reserves the right to use its sole discretion in determining whether the information supplied is acceptable for timely filing purposes.

Billing References

Current HCPCS and CPT Manuals must be used because many changes are made to these codes quarterly or annually by the designated code set owner. These manuals may be purchased at any technical book store or by writing to:

Mail Orders
American Medical Association
Attention: Order Processing
P.O. Box 930876
Atlanta, GA 31193-0876

Or by calling:

- The Practice Management Information Corporation (PMIC): **800-633-7467**
- The American Medical Association**: 800- 621-8335**