WELCOME TO NAVIGATING THE BLUES!

B I L L I N G O R I E N T A T I O N

Today's seminar will provide valuable information on our billing guidelines, remittances, website tools and much more.

Excellus

Everybody Benefits

BASIC BLUE 101

- Billing Overview & Highlights
- Electronic & Paper Claims
- Provider Remittances
- Troubleshooting Outstanding Claims
- Website Tools

CLAIM SUBMISSION OVERVIEW

Submitting Claims

- As a participating provider, you need to submit all claims, including those for **local subscribers**, **out-of-area subscribers** and **primary** and **secondary claims**, to your local BlueCross BlueShield plan.

- Most participating provider agreements contain a time limit within which claims will be accepted, so providers should submit all claims as soon as possible after rendering service. Claims submitted after that time limit may deny for late filing.

- Excellus BCBS accepts both paper and electronic claims.

- For workers' compensation and no-fault claims, please use the *No Fault, Workers' Compensation and Medicare Exhausted Benefits* form available via our website, Provider.ExcellusBCBS.com > Get Help > Find a Form > Billing and Remittance.

CLAIM SUBMISSION OVERVIEW

Claim Filing Limits

- Submit all claims as soon as possible after rendering service (or after the processed date of a primary payer's explanation of benefits or EOB)
- Professional providers: 120-day claim filing limit applies
- Hospitals: Refer to hospital contract for claim filing limit
- The filing limit for Coordination of Benefit claims begins on the date of payment from the primary payer
- Claims submitted after the time limits will be denied for late filing

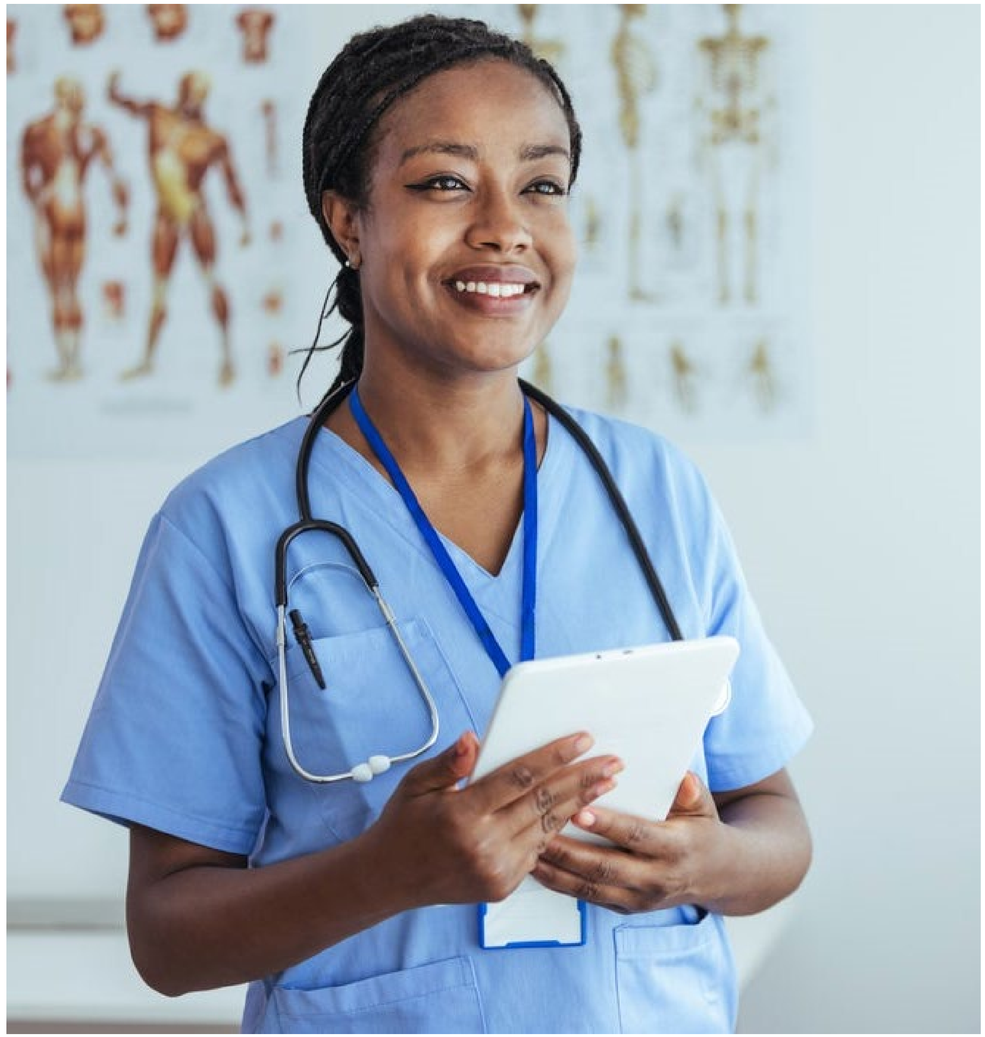
Secondary Claims

- Our subscriber contracts allow us to coordinate payments with other payers when a member is covered by more than one policy, which is called Coordination of Benefits (COB). COB claims can be submitted electronically
- To balance secondary electronic claims, the following information is required from the primary carrier's EOB: allowed amount, deductible and coinsurance applied, reduction of charges taken, payment amount and patient responsibility
- For secondary paper claims, we require a copy of the primary carrier's EOB with the submission of the secondary claim. Please attach the primary EOB to a separate sheet of paper

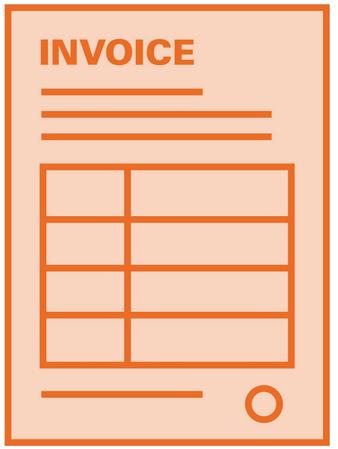
CLAIM SUBMISSION OVERVIEW

Medicare Crossover Claims

- Please do not send claims to us if the primary payer is Medicare. Medicare will cross the claim over to us directly.
- For out-of-area BCBS plans, Medicare will crossover claims directly to the member's BCBS plan.
- If the EOMB from Medicare indicates that the claim has been forwarded for processing, please suppress the secondary billing of these claims.
- If you do not receive payment from us for a secondary Medicare claim, please wait a minimum of 30 days from the Medicare payment date before submitting the claim to us.



BEFORE YOU BILL



Helpful hints to follow before billing a claim

- Verify the patient's insurance information at the time of the visit including eligibility, benefits and preauthorization requirements for the services that will be performed.
- Verify that you are a participating provider with the patient's insurance or the specific product for that patient.
- If the patient has managed care coverage and you are providing primary care services, verify that you are the PCP listed on the patient's member card and with the insurance company.
- If you are **not** listed as the PCP on the member card, the member must contact us to update his/her PCP information, or a referral must be obtained. If neither of these situations occurs, services will not be covered, and the patient will be held harmless (not be responsible for payment).
- If the patient has a managed care contract and you are a specialist, verify if a referral from the PCP is necessary and on file (if applicable).
- If a referral is necessary and is not on file, the service will not be covered and the patient will be held harmless (not be responsible for payment).
- If the patient has a limited number of visits for a specific service (e.g., physical therapy), verify the number of visits left before or at the time of service.
- Collect the copayment from the patient at the time of visit.

BEFORE YOU BILL

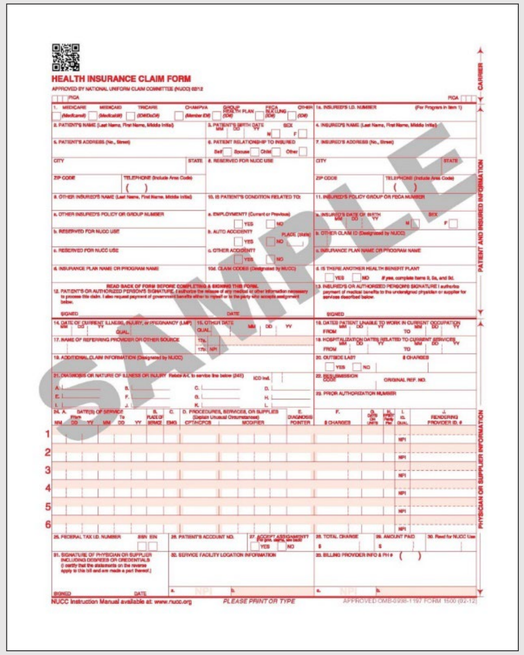
Billing Information

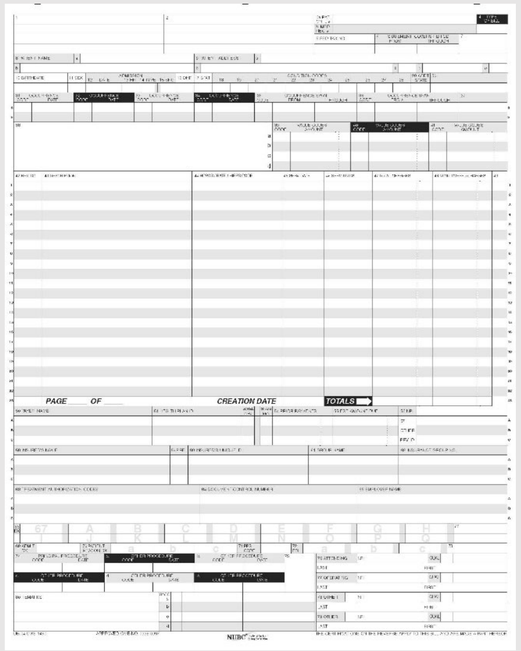
In order to submit claims, you will also need the following:

- Your tax identification number
- Provider name and address
- NPI number
- Group NPI number (if applicable)
- Taxonomy code
- Date of service
- Place of service
- Procedure code
- Diagnosis code
- Number of days/units
- Charges

CLAIM FORMS

Paper claims must be submitted on the CMS-1500 claim form for professional providers. The UB-04 is the standard claim form to bill when a paper claim is allowed for institutional providers.





Submitting claims electronically is preferred. You should only submit paper claims if it's not possible to submit the claim electronically.

Get Help > Search Tip Sheets > Tips for Completing the CMS 1500 Form

ELECTRONIC CLAIMS

Electronic claim submission is the fastest, most efficient way to submit claims for reimbursement. In addition to its many advantages, electronic claim submission is mandated by New York State Public Health Law.

The Excellus BCBS clearinghouse allows submitters to electronically transmit claims using the standard ANSI claim formats (837I for institutional claims, 837P for physician/medical claims and 837D for dental claims). A submitter is defined as a provider in the Excellus BCBS service area, a clearinghouse or a third party supplying billing services. Our EDI department maintains our clearinghouse.

EDI Solutions Support Assistance:

You may contact the EDI Solutions for questions regarding:

1) How to become an electronic biller.

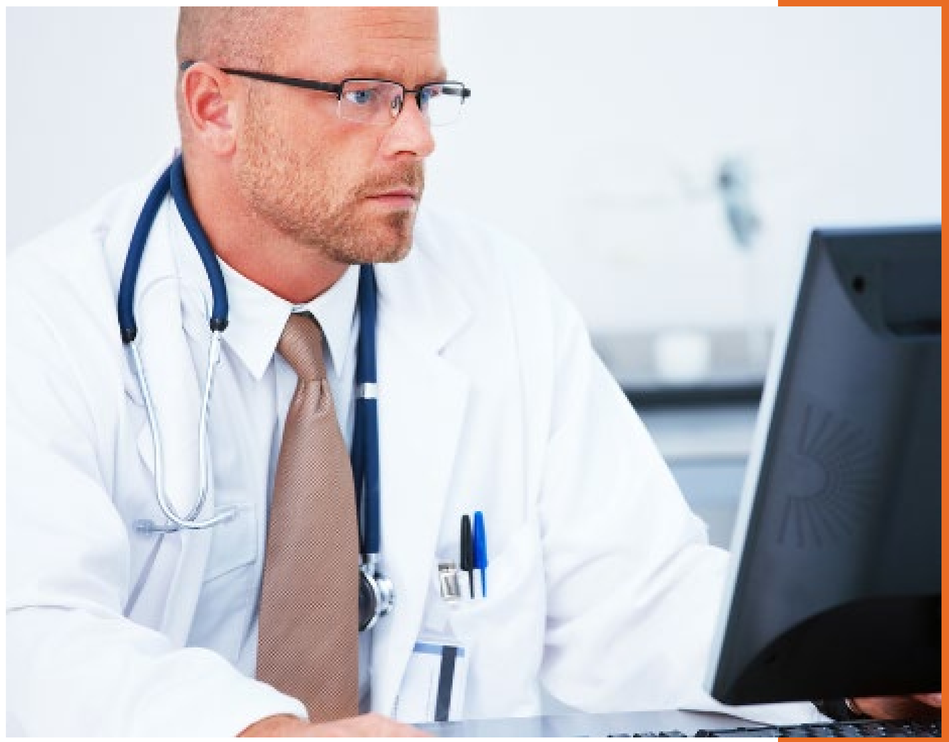
2)If you are an electronic biller, questions regarding your claim transmission or any rejections.

EDI Solutions email: edi.solutions@excellus.com

eCommerce Support

If you have questions regarding electronic submissions, contact eCommerce Support by email at ecommerce.excellus@excellus.com

ELECTRONIC CLAIM PROCESSING



Electronic Claims Submission

Claim Validation and Editing:

- First step in the clearinghouse process
- Applies high level edits such as:
  - verification that mandatory fields/ required records have been populated
  - alphanumeric/numeric checks
  - field length checks
  - code validation

Editing performed at four levels:

File level: If an error is encountered at the file level, the clearinghouse will reject the entire file and will report this on the TA1 clearinghouse report.

Batch level: If an error is encountered at the batch level, the entire batch will be rejected. This will be reported on the 999 and 277CA clearinghouse reports.

Claim level: A claim level error will result in rejection of that claim and be reported back to the submitter on the 999 and 277CA clearinghouse reports. Claims that are accepted by the clearinghouse continue through the claim distribution function to be routed to the appropriate payers.

Payer level: A payer system error will result in rejection of the claim. This will be reported on the Payer Response report. This is a proprietary report that is also known as the NYSCOP report.

COMMON REJECTIONS FOR ELECTRONIC CLAIMS

Misrouted Claim (through the ITS system)

- Prefix on this claim is incorrect. Contact the patient or use our website to obtain the correct prefix information.

Special Characters in the Insured's First or Last Name Not Allowed

- The claim you are submitting has hyphens or apostrophes in the name. Only alpha characters are allowed. Enter the name exactly as it appears on the member card.

Patient Sex or Birthdate does not Match Membership

- The patient's sex or birthdate does not match our membership. One of the two systems is incorrect - if it's your data, correct the information and resubmit. If it is our data, have the patient contact us to correct our information, and then you will be able to resubmit the claim.

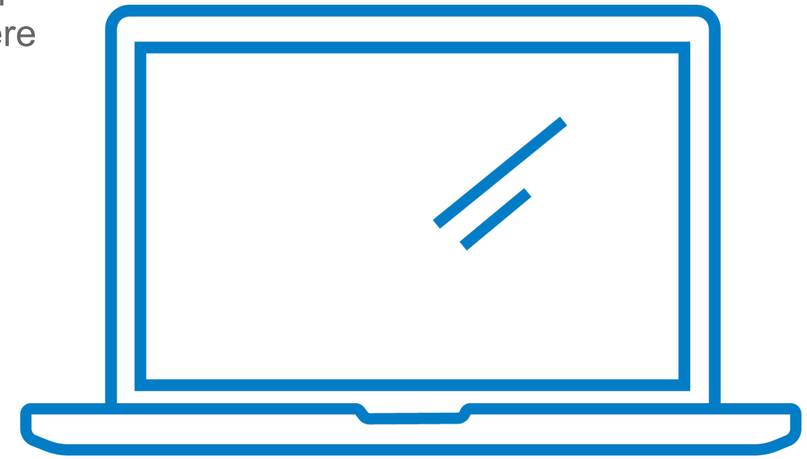
Claim Billing Errors

- Provider is not registered to bill under Tax ID or group NPI; date of service is prior to the effective date or after the termination date of the Tax ID.

COMMON REJECTIONS FOR ELECTRONIC CLAIMS

No Coverage Located on Membership

- You may receive this message if you used an incorrect prefix and the claim hits against the wrong system. For the information you have submitted, there is no active or terminated coverage found.
  Verify with the patient their insurance coverage information.



Medicare Claim Out of Balance

- Information is incorrect with your primary payment information and the payment that you are seeking. Contact your vendor to correct the appropriate fields for secondary claims.

Terminated CPT/HCPCS or Procedure Code

- The procedure code that you submitted is terminated within the payer system. Investigate if a new
  code has been implemented by CPT/HCPCS.

EXCELLUS BCBS REMITTANCE HIGHLIGHTS

Reimbursement Highlights

Paid-in-Full and Hold Harmless

We pay participating providers directly for covered services.

You accept our payment as payment-in-full and have agreed to not collect from or bill our member.

However, make sure you collect the copayment, coinsurance, deductible and member penalty when applicable.

Fee Schedules

Fee schedules may vary by product (Commercial, Medicare Advantage, Government Programs & Special Programs)

Fee schedules are available on our website and updated annually for physicians. To access, you must login with your Excellus BCBS username and password as this information is housed on a secure section of our website.

Recouping Incorrect Payments

In the event that Excellus BCBS makes an incorrect payment or an overpayment, our provider
contracts allow us to make necessary and appropriate adjustments in the form of offsets and/or retractions from future payments.

In some cases, you will receive a 30-day notice of retraction.

REMITTANCES

Remittances and checks are processed on a weekly basis.

ID numbers currently on the Facets system begin with a three-character prefix and a nine-digit number beginning with “200,” “201”, “202”, “203” or “M20.”

Electronic Remittances:

You can choose to receive your remits electronically in place of paper remits.

Contact your vendor to receive your electronic remittance from our clearinghouse.

Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT):

Excellus BCBS partners with InstaMed to offer web-based ERAs and EFTs. For more information, call 1-800-211-1416, or visit our website, Provider.ExcellusBCBS.com > Claims & Payments > Electronic Payments and Remittances

Note: To visit the InstaMed website directly, go to www.instamed.com.

EFT and ERA through InstaMed enables you to:

- Accelerate payments with direct deposit into your existing bank account
- Save time and money by eliminating paper checks and remittances
- Receive fully reconciled remittances electronically
- Access payment details, view and print remittances 24 hours a day, seven days per week

REQUESTING CLAIM ADJUSTMENTS

Claim Adjustments

Common reasons for claim adjustments include:

- An overpayment where you need to request that Excellus BCBS retract the overpaid monies
- A claim denied incorrectly, where a retraction and reprocessing may be necessary
- A submission of a corrected claim that denies as a duplicate claim in error

In these cases, you will need to request that the claim is reprocessed, or you may need to submit a corrected claim.

Requesting Adjustments

Online: (for local claims)

Go to Claims & Payments > Request Adjustment > Claim Adjustment Request Online

Note: You must be a registered website user to access this tool.

Enter the requested information in the fields (e.g., subscriber ID, DOB, NPI). When you have successfully located the claim, select the claim for more details and you will see a link to the online adjustment form. If the claim has not been reprocessed after 30 days, contact Customer Care for a status update.

Adjustment Form:

The Claim Adjustment or Retraction Request paper form is available via our website.

Customer Care: When you call, be sure to have the following information:

1) Your tax ID number or NPI
2) Patient's ID number
3) Date of service
4) Details of your adjustment request

EXAMPLES OF CLAIM ADJUSTMENTS

Overpayments or Credit Balances:

If you received an overpayment, the easiest way to remedy the account is to request a retraction. This can be done through any of our adjustment methods.

You will see the retraction on a future remittance and future monies will be held to cover the money owed.

For COB claims, where we paid as a primary and should have been secondary, there is a possibility that the patient has not informed us that another carrier is primary. Claims will continue to
pay as primary until the patient contacts us with the correct information.

Claims Denied Incorrectly:

There may be times when claims are denied in error. Examples: A claim that denied as a duplicate even though only one claim has been submitted; a claim that denies for no authorization even though an authorization is on file.

You can request that these claims be reprocessed through any of our adjustment methods.

Resources > View Forms and Documents > Billing and Remittance

BLUECARD® CLAIM ADJUSTMENTS

BlueCard links participating health care providers and BCBS plans across the country and around the world through a single electronic network for claims processing and reimbursement. The program allows your office to submit claims for patients from other BCBS plans directly to your local plan. Your local plan will be your contact for claims payment, problem resolution, adjustments and inquiries.

Out-of-Area Claims Handled by the Home Plan

All out-of-area BCBS claims (including secondary claims) must be submitted to your local plan for processing.

The local plan will pass the claims to the out-of-area plan (member's Home Plan) for processing.

It is up to the member's Home Plan to pass the claim back to the Local Plan for provider payment.

You will receive a denial code on your local remittance that the claim has been forwarded to the Home Plan for processing.

Out-of-Area Claims Denied for Service Not Covered

When a claim denies as non-covered service and the member is out-of-area, contact the member's Home Plan to verify benefits (and to confirm if the denial is correct).

Out-of-area benefit information is not available in the local plan's system.

If you are informed that the service should be covered, contact the local plan to reprocess the claim.

To contact a member's Home Plan, call 1-800-676-BLUE and provide the three-character prefix.

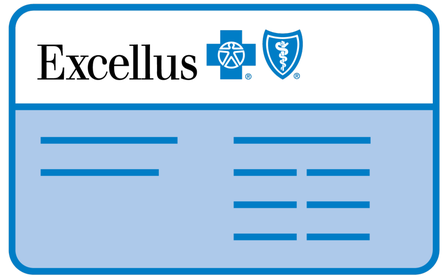
Out-of-Area Claims Denied for No Authorization

If a service requires a preauthorization for an out-of-area member, an authorization must be on file with the member's Home Plan.

If a claim denies for no authorization, contact the Home Plan to verify that an authorization is in place.

If an authorization is in place, contact the local plan to reprocess the claim.

Resources > The BlueCard Program



CLINICAL EDITING DENIALS

As part of the claims adjudication process, our claims systems will review a claim to determine that it fulfills our medical policies, referral requirements, preauthorization requirements and other benefit management specifications.

Appeals for Clinical Editing Denials

- If changes are being made to a claim with a clinical editing denial, a Clinical Editing dispute submission is no longer required. Simply correct your claim electronically using our web portal at Provider.ExcellusBCBS.com.
  - ✓ A corrected claim submission does not guarantee payment. The corrected claim will re-adjudicate through the claim processing system and edit(s) may remain and/or additional edits may apply.
- You must use our online Clinical Editing (CE) Dispute tool or our Clinical Editing Review Request form forthe following exceptions:
  - ✓ CE disputes with coding validation (CV) denials (Explanation codes Z01, Z12, Z13, Z19, Z20, Z26, Z31 and Z52
  - ✓ If you are not making any changes to the claim and disagree with the clinical edit
- The dispute form is available via our website, Provider.ExcellusBCBS.com > Resources > View Forms and Documents > Clinical Editing.
- Clinical editing appeals go through a review process and the outcome of the committee's decision will berelayed to you in writing.
- You have 365 days from the date of the remittance advice to request a claim review for clinical editing.

INVOLVING THE MEMBER

When to Involve the Member

It is your patient's responsibility to provide you with his/her insurance information.

If the patient is unable to do this at the time of service, he/she is responsible for the bill until that information can be obtained.

Once insurance information is obtained, you must submit claims on his/her behalf.

If the claim is over the timely filing limit, you must submit the Request for Timely Filing Review form with the claim. The form is available via our website.

Many times, patients will have copayments, coinsurance and/or deductibles that are applied and reduced from payment. We recommend that you collect copayments and deductibles at the time of service.

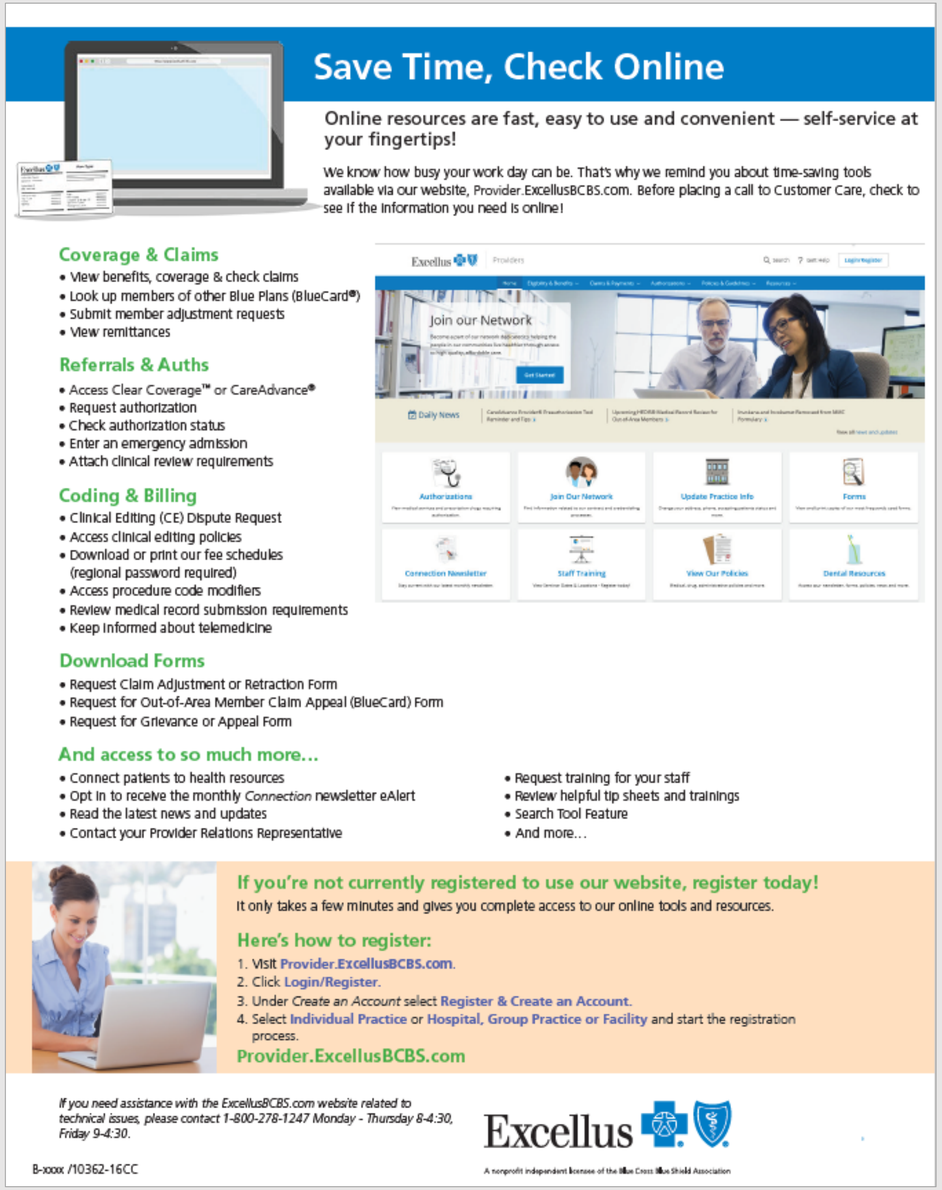
Many providers act as a patient's advocate with the insurance company; however, when an insurer correctly denies a claim, it is best to advise the patient to call his/her insurer with questions.

The phone number for Customer Care (a.k.a. Customer Service) is located on the member card.

WEBSITE

Save Time, Check Online!

- Visit Provider.ExcellusBCBS.com:
- Check claim status and request adjustments
- Check, enter, update and delete referrals
- Check member eligibility and benefits
- Enter an emergency admission
- View clinical review requirements
- Update practice information
- Review referral guidelines
- Request preauthorizations
- Read medical policies
- Review Provider Manuals
- Connect patients with health resources
- Access to prescription drug information– medication guide, prior authorization forms, specialty pharmacy network
- Download forms
- And MORE!



Save Time, Check Online

Online resources are fast, easy to use and convenient — self-service at your fingertips!

We know how busy your work day can be. That's why we remind you about time-saving tools available via our website, Provider.ExcellusBCBS.com. Before placing a call to Customer Care, check to see if the information you need is online!

Coverage & Claims
- View benefits, coverage & check claims
- Look up members of other Blue Plans (BlueCard®)
- Submit member adjustment requests
- View remittances

Referrals & Auths
- Access Clear Coverage™ or CareAdvance®
- Request authorization
- Check authorization status
- Enter an emergency admission
- Attach clinical review requirements

Coding & Billing
- Clinical Editing (CE) Dispute Request
- Access clinical editing policies
- Download or print our fee schedules (regional password required)
- Access procedure code modifiers
- Review medical record submission requirements
- Keep informed about telemedicine

Download Forms
- Request Claim Adjustment or Retraction Form
- Request for Out-of-Area Member Claim Appeal (BlueCard) Form
- Request for Grievance or Appeal Form

And access to so much more...
- Connect patients to health resources
- Opt in to receive the monthly *Connection* newsletter eAlert
- Read the latest news and updates
- Contact your Provider Relations Representative
- Request training for your staff
- Review helpful tip sheets and trainings
- Search Tool Feature
- And more...

If you're not currently registered to use our website, register today!

It only takes a few minutes and gives you complete access to our online tools and resources.

Here's how to register:
1. Visit Provider.ExcellusBCBS.com.
2. Click Login/Register.
3. Under *Create an Account* select Register & Create an Account.
4. Select Individual Practice or Hospital, Group Practice or Facility and start the registration process.

Provider.ExcellusBCBS.com

If you need assistance with the ExcellusBCBS.com website related to technical issues, please contact 1-800-278-1247 Monday - Thursday 8-4:30, Friday 9-4:30.

B-xxxx /10362-16CC

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

WEBSITE

You must be a registered website user to have complete access to online tools and resources.

Registering only takes a few moments.

Visit Provider.ExcellusBCBS.com

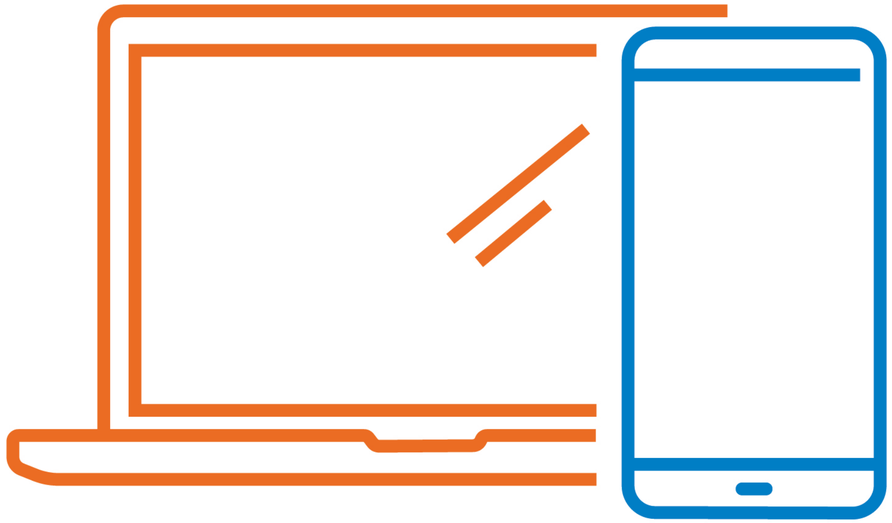
Click Login/Register

Click Register & Create an Account

Select “Hospital, Group Practice or Facility” or “Individual Practice”

Enter your information on the Registration Form and submit

Log in with your username and password



Need Assistance Registering?

Contact the Web Security Help Desk at 1-800-278-1247.

Your Provider Relations representative is also available for training on Web registration and functionality.

DISCUSSION

QUESTIONS?

OUR MISSION

To help people in our communities live healthier and more secure lives through access to high-quality, affordable health care.

OUR VISION

To be recognized and valued as THE community and business resource for health care security through financial strength, effective cost control, ease of use, and commitment to health improvement.

Excellus

Everybody Benefits

THANK YOU