Claim Investigation Submission Guide

August 2017

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.
The Claim Investigation Submission transaction lets you submit questions or comments about a claim for Independence Blue Cross (Independence) members through the NaviNet® web portal. You can then track and review the health plan’s response to your questions using the Claim Investigation Inquiry transaction.

**Important notes**
- The Claim Investigation link is available for claims in a finalized status.
- Claim Investigation submissions for pre-migrated claims are no longer supported.
- Claim edits and claim corrections are not permitted through Claim Investigation.
- Claim Investigation is by claim and not by line item. If you need to draw attention to a specific claim line, enter that line number in the Investigation Comments box.
- Please be specific when describing the reason for the claim review. *Note:* If a claim is denied for lack of referral or authorization and one was required, you must submit a valid referral or authorization number in order for the claim to be reconsidered. See the *Best practices for common claim review requests* section at the end of this guide.
- A response for a Claim Investigation is generally expected within 30 days after submission.

*Please note:* If you have a large volume of claim review requests for the same issue, please contact your Network Coordinator to discuss *before* submitting multiple claim review requests through NaviNet.

**Accessing Claims: Claim Search**
To begin, first perform a Claim Status Inquiry to locate the claim. Select *Claim Inquiry and Maintenance* from the Independence Workflows menu, and then select *Claim Status Inquiry*. This will take you to the Claim Status Search screen.
On the Claim Status Search screen, enter your search criteria to find a claim.
1. Select the **Billing Entity** field to display the list of provider groups or use the type-ahead feature and type the billing entity group name, NPI, provider ID, or address. Select the provider from the drop-down list returned.

*Note:* If the number of provider groups associated with your NaviNet office is too large, you will see the message “Too many results found, please narrow the search criteria.” You may need to use the type-ahead feature to locate the desired provider group.

![Billing Entity field](image)

2. Search by Member ID or Patient Name and Date of Birth:
   - For a Member ID search, enter Member ID as it appears on the member’s identification card.
   - For a Patient Name search, enter Last Name, First Name, and Date of Birth (mm/dd/yyyy).

When searching by Patient Name and Date of Birth, if more than one record matches your search criteria, the Patient Search Results screen will display.

![Patient Search Results](image)

You will then need to select the appropriate record to view the list of associated claims.

3. For Service Start/End, enter a claim start date (mm/dd/yyyy) or click the calendar icon to select a date. *Note:* The updated transaction will eventually allow you to search for a member’s claim up to three years in the past from the current date. However, initially you will only be able to access claims processed on our new platform. You cannot search for pre-migrated claims processed on our legacy platform.

4. Claim ID is an optional field and is used to filter your search. *Note:* Searches cannot be performed by entering a Claim ID alone.

5. After entering all claim search criteria, select **Search**.
For finalized claims, you can access the Claim Investigation link from either the Claim Status Search Results screen or the Claim Status Details screen.

Claim Investigation link from the Claim Status Search Results screen
To access the Claim Details screen from the Search Results screen, select the Claim ID link for the desired patient. For finalized claims, you can select Claim Investigation to start an investigation for a specific claim.

Claim Investigation link from the Claims Status Details screen
On the Claim Status Details screen, you can view the detailed claim information for your patient. For a finalized claim, select Claim Investigation to start a claim investigation.
Once you select *Claim Investigation*, the Investigation Entry pop-up appears. You will need to complete this form by following the below instructions.

Select the reason for your request by selecting a description from the Investigation Type drop-down list.

Enter your comments for the investigation reviewers. Please be specific when describing the reason for the investigation. In the remaining fields, enter the contact information specific to this investigation.

Populate the remaining fields regarding the contact. Once complete, select the *Submit* button **one time only**. The submission of your completed investigation may take a few moments.

*Please note:* Do **not** press the *Enter* key on your keyboard when completing a Claim Investigation request as this may submit the request prematurely.
The system will display a confirmation screen when the submission is complete.

![Investigation Claim # 12345678911 was submitted](image)

Your Investigation Request for Claim # 12345678911 has been submitted to the plan. Our goal is to respond to your inquiry within 7 days, however, at times due to volumes of complexity our response may take up to 30 days.

To inquire about the submitted investigation in the future, use the Claim Investigation Inquiry transaction.

**Claim Investigation Inquiry**

Select *Claim Inquiry and Maintenance* from the Independence Workflows menu, and then select *Claim Investigation Inquiry*.

![Workflows for this Plan](image)

On the Claims Investigation Inquiry Search screen, enter your search criteria to track your investigation. See image on page 8.

1. Select the *Billing Provider* field to display the provider list and select the appropriate Billing Provider.
2. The displayed Request Date From and Request Date To dates default to the most current 30-day period. These dates can be modified.
3. Narrow your search by Adjustment ID (optional field).
4. Narrow your search by Investigation Status – Submitted or Closed (optional field).
5. After making all selections, select *Search*. 
On the Claims Investigation Search Results screen, select the Request Date link for the correlated member to access the Claim Investigation response screen. *Note:* A Closed status indicates that the health plan has responded to the investigation. An investigation status of Submitted indicates the request remains under review.

The Claim Investigation response screen will open.
If the Claim Investigation has been closed, the Investigation Reply will appear below the Investigation Comments.

If the claim has been adjusted, the details may appear in the Adjusted Service Line Detail section.

Best practices for common claim review requests
Follow the guidelines below to help expedite processing of your claim review requests.

Submission preparation
Prior to submitting a claim review request for facility pricing, take the following steps:

- Using the Claim Investigation Inquiry transaction, confirm that there is not an existing investigation for the same claim that may have been previously submitted by your office.
- Verify the line of business (LOB) for the member’s benefit plan, the member’s coverage effective date compared to the date of service (DOS), and the member’s eligibility for the service(s) performed.
- Review your Independence Agreement effective date and expected reimbursement.
• Review the admission date and discharge information. *Note:* Remittance is established by the date of admission, regardless of a change in the provider’s Agreement or member’s benefit plan during an inpatient stay. Refer to field 12 on the UB-04 claim form for the date of admission and fields 16 and 17 for the discharge status.

![Claim Form Image]

• Verify the status of the authorization, if applicable (i.e., pending vs. approved, level of care, dates of service, and service(s) performed).

In addition, please review the following:

• **Modifiers.** The application of modifier pricing is administered per Ambulatory Payment Classifications (APC)-based outpatient contracts only. Independence does not acknowledge modifiers if you are a facility that is contracted according to the outpatient fee schedule (i.e., not through APC [non-APC]).

• **Quarterly fee schedule updates.** As outlined in your Independence Agreement, due to changes in clinical practice and/or modifications to standard coding systems, we may add, delete, and/or re-categorize the fee schedule for outpatient procedures. Independence provides a 30-day advanced written notice to facilities of such changes. It is imperative that these changes are reviewed to ensure accurate billing and claims reimbursement.

*Quarterly fee schedule updates are not applicable to skilled nursing facilities.*

• **Pharmacy fee schedule.** Confirm if your facility is currently contracted per the Outpatient Cost-Based Pharmacy Fee Schedule.

• **For APC facilities.** In the event the Centers for Medicare & Medicaid Services (CMS) makes updates to APC Grouper/Pricer and/or Fee Schedules, Independence will update the APC Grouper/Pricer within 60 days of CMS publishing such updates. The parties agree, however, that retrospective changes made by CMS shall not apply.

**Claim Investigation Submission**

When submitting a claim review request for facility pricing variances, the following information must be included in order for Independence to research your request:

**Inpatient claims**

The inquiry must include certain information, depending on your reimbursement methodology:

• **Diagnosis related group (DRG).** If you are questioning the manner in which a DRG inpatient claim is paid, the inquiry must include the following:
  – expected DRG;
  – its base rate;
  – its weight;
  – adjustment factor;
  – whether you expect the inlier, outlier, or transfer rate.
• **Per diem.** If you are questioning the manner in which a per diem inpatient claim is paid, the inquiry must include the following:
  – revenue code(s);
  – number of days;
  – expected per diem rate.

**Outpatient fee schedule claims**
If you are questioning the manner in which outpatient fee schedule claims are paid, the inquiry must include the following:
- procedure code(s);
- corresponding base rate (Note: Our fee schedules are updated quarterly; therefore, please ensure you are pulling the base rate from the fee schedule that corresponds with the claim DOS);
- adjustment factor.

**APC claims**
If you are questioning the manner in which APC claims are paid, the inquiry must include the following:
- date of the APC version;
- adjustment factor.

*Note:* Independence currently receives hundreds of APC pricing inquiries per month that do not meet the criteria for adjustment because the pricing differential is due to CMS retrospective updates.

If you have questions about using the Claim Investigation Submission transaction, call the eBusiness Hotline at 215-640-7410.

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