BlueCross BlueShield of North Carolina

Effective: August 8, 2023

How to Submit Proactive Medical Records for Medical Necessity Reviews (does not affect those records that will continue to be requested by our Medical Review Staff)

When you've identified a service, procedure, or supply that may require medical records to determine **medical necessity,** please submit the medical records in advance of filing the claim. By sending the records first, Blue Cross NC will be able to locate and match the supporting medical records to the claim once it is submitted. Submitting the claim before the medical records are received by Blue Cross NC ***will create the potential risk of the claim being processed and denied due to missing medical necessity information.*** Blue Cross NC can accept medical records to support claims of medical necessity, which have not yet been processed by Blue Cross NC, via the following methods: FAX, certified mail, or the secure online message system ProviderLink (Please speak with your Provider Service Consultant for more information on this application).

To remain compliant to HIPAA Minimum Necessary regulations, providers should not submit medical records for CPT, HCPCS or Revenue code that are not listed on Blue Cross NC's listings for "Codes by procedure types requiring medical records submissions" and "ICD-10 Diagnosis Codes to be filed in conjunction with Revenue Code 0360, 0272, 0278 and 0922 and requiring medical records submissions" (Note 1). All other medical records received for codes not included on these lists will be subjected to Blue Cross NC's un-solicited medical record processes.

Submitting Proactive Medical Records

Use the following information to submit proactive records (records submitted in advance of filing a claim).

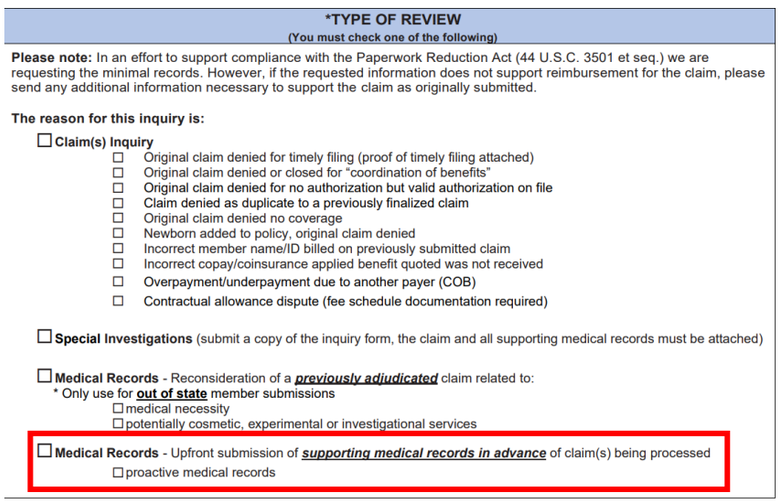
Open the following link to create a form that is **required** to be sent with faxed and mailed records.
provider_claim_inquiry.pdf (bluecrossnc.com)

IMPORTANT

a) Records will not be reviewed or processed if the form is not filled out in its entirety.
b) **Submit only one form per member.**
c) This form is **not** for new or corrected claim forms.
d) To support compliance with the Paperwork Reduction Act (44 U.S.C. 3501 et seq.), we are requesting that minimal records be sent that support reimbursement for the claim.
   - If 300 or less pages, you may submit by fax or certified mail.
   - If 301 or more pages, only certified mail is accepted.

How to complete the form for proactive record submission

- Information, Fax number, and Mailing address can be found at the top of the form under Instructions.
- Disregard the first bullet under Instructions on the form – (Use this form to request review of a previously adjudicated claim)
- Provider Information, Clinical Information, and Member Information must be completed in their entirety. Since these records are being submitted prior to submitting a claim, please enter Proactive Records in the claim number space.
- Type of Review (bottom of the page)
  - Check the Medical Records box – Upfront submission of ***supporting medical records in advance*** of claim(s) being processed.
  - Check the proactive medical records box.



***TYPE OF REVIEW**
(You must check one of the following)

Please note: In an effort to support compliance with the Paperwork Reduction Act (44 U.S.C. 3501 et seq.) we are requesting the minimal records. However, if the requested information does not support reimbursement for the claim, please send any additional information necessary to support the claim as originally submitted.

The reason for this inquiry is:

☐ **Claim(s) Inquiry**
- ☐ Original claim denied for timely filing (proof of timely filing attached)
- ☐ Original claim denied or closed for "coordination of benefits"
- ☐ Original claim denied for no authorization but valid authorization on file
- ☐ Claim denied as duplicate to a previously finalized claim
- ☐ Original claim denied no coverage
- ☐ Newborn added to policy, original claim denied
- ☐ Incorrect member name/ID billed on previously submitted claim
- ☐ Incorrect copay/coinsurance applied benefit quoted was not received
- ☐ Overpayment/underpayment due to another payer (COB)
- ☐ Contractual allowance dispute (fee schedule documentation required)

☐ **Special Investigations** (submit a copy of the inquiry form, the claim and all supporting medical records must be attached)

☐ **Medical Records** - Reconsideration of a ***previously adjudicated*** claim related to:
* Only use for **out of state** member submissions
- ☐ medical necessity
- ☐ potentially cosmetic, experimental or investigational services

☐ **Medical Records** - Upfront submission of ***supporting medical records in advance*** of claim(s) being processed
- ☐ proactive medical records

For providers with an active ProviderLink *On-Line* Contract

Please use the following instructions for submitting "pro-active" medical records via ProviderLink *online*.

1) Providers can use the 'online' message feature to submit medical records independent of the claims. Please identify the message type by entering "**Pro-active Records**" as the message subject.
2) Please ensure that the following information is clearly documented in the ProviderLink *On-Line* message header:
   a) The patient's name.

b) The Blue Cross NC patient's ID Number (including the Prefix and Suffix) in the Unique ID field.
c) The patient's Date-of-Birth
d) The Date-of-Service
e) Sender's name and direct phone number on the message header (Blue Cross NC will contact the individual listed if there are any questions about the received document).

3) Please **do not** "Request a Reply" (Note 2) to the message when submitting proactive medical records. Blue Cross NC recommends utilizing the Audit Trail feature within the application. Contact Covisint for additional information about "Audit Trail" features.
4) Submit the medical records to the corresponding ProviderLink **Online "Facility" Post Claim mailbox** that is associated with the patient's Insurance coverage type, e.g., Commercial, SHP.

Note 1: Blue Cross NC accepts medical records in advance of processing claims reporting unlisted services provided to Medicare Advantage members.

Note 2: Requesting a Reply causes the patients' files to be assigned to a specific work list within the Blue Cross NC application and will cause additional and unnecessary incoming messages within our system.