EDI News

Changes to BlueCard Claims Submission When Medicare is Primary

In order to prevent duplicate claims processing and ensure accurate claims pricing, Premera Blue Cross will handle BlueCard claims differently when Medicare is the primary payer. This change is effective Oct. 13, 2013.

What is the Change?

Providers must wait 30 days from the Medicare process date before submitting a claim to Premera if the Explanation of Medicare Benefits or 835 (Electronic Remittance Advice) indicates the claim was forwarded (or crossed over) to the secondary payer (Premera). Premera will send back claims received before the 30-day waiting period has passed or reject those claims through the EDI (electronic billing) process.

In addition, providers should submit claims for services not covered by Medicare to Premera (not to the member's home plan). This allows Premera to apply the contracted rate to the claim.

- For services statutorily excluded by Medicare, the provider should list a GY modifier for each line with a service that is excluded.
- For services that Medicare does not cover because the benefit was exhausted, the provider must include Medicare adjudication that shows that benefits were exhausted.

Why Are We Making This Change?

We are making this change in accordance with a national Blue Cross Blue Shield Association guideline. We believe that this requirement will reduce duplicate claims processing, ensure accurate claims pricing and create consistency when billing to various Blue Plans throughout the country.

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Additional Support

For questions about this article contact Physician and Provider Relations at 877-342-5258, option 4.

- To check claim status or obtain benefits or eligibility for a BlueCard member:
  - Visit our website at **premera.com/ak/provider**
  - Call 800-676-BLUE (2583)
  - Submit an electronic 270-Healthcare Eligibility and Benefits Inquiry, to find out more about using the 270 contact EDI at 800-435-2715 or **edi@premera.com**.
- For questions about electronic billing contact EDI.
- For questions about this article contact Physician and Provider Relations at 877-342-5258, option 4.

Premera's ICD-10 Implementation Approach

When we initiated our ICD-10 assessment in 2010, we established the following guiding principles:

- Achieve compliance by the date mandated by the Department of Health and Human Services (HHS)
- Maintain provider (i.e., physician and hospital) payment neutrality
- Avoid impacts to member benefits
- Be flexible in claims processing approach to do what is right for our members, our providers, and our groups, while meeting HHS compliance
- Sustain current claims auto-adjudication rates
- Maintain customer service call performance

Premera will be compliant and is also expecting providers to be compliant. To meet that requirement, we'll be capable of processing both ICD-9 and ICD-10 codes and will process claims natively using the ICD codes submitted on the claims.

(continued)

Our ICD-10 approach will be flexible and allow for adjustments as needed.

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ICD-10 (continued)

Per the regulation:

For services received on or after Oct. 1, 2014, we expect providers to submit claims containing ICD-10 diagnosis codes and procedures.

For claims/claims adjustments with dates of service before Oct. 1, 2014, we will process claims containing ICD-9 codes.

Premera's Current Status: ICD-10 Analysis and System Remediation

During the past three years, we have completed the ICD-10 mapping of member benefits into the new code set, documented our business requirements, and remediated core claims processing systems as required for ICD-10. With the Oct. 1, 2014 revised compliance date, the team adjusted the project schedule to accommodate the year delay and is currently executing the revised plan. Our current focus is completing remediation of other systems and initiating testing by third quarter 2013.

Validation and Testing

ICD-10 testing has been structured into several phases beginning in Q1 2013 and ending by mid-2014. We are currently planning our provider (physician and hospital partners) testing strategy and will reach out to providers in Q3 2013 to initiate testing. Actual testing schedules will be determined upon completion of the strategy and initial discussions with providers.

Based on the market response to the mandate, our ICD-10 remediation approach will be flexible and allow for adjustments as needed. Our goal is to ensure we are serving our customers – providers and members.

If you have specific requirements that we should consider as we move forward, we welcome your feedback. We also welcome your thoughts about future testing requirements and plans that will be needed to ensure that we are jointly ready and capable of serving our customers.

We'll work collaboratively with healthcare providers to assist in their compliance efforts for the ICD-10 mandate. Find more information under Quick Links at at **premera.com/ak/provider**.

Alpha Plan Prefix List Now Online

Premera recently published a list of alpha plan prefixes, in response to provider requests to verify valid prefixes. The alpha plan prefix precedes the member's ID number on the member's ID card, such as:

ZKA 123456789

We highly recommend sending the alpha plan prefix (when known) with the member ID on all claims.

Be sure and verify the patient's most current Premera ID card by looking for the "Date Printed" but note that Premera ID cards are not always re-printed each year.

To view the published Premera Alpha Plan Prefix list, go to: premera.com/wa/provider, Reference Info and Tools.

To access the Alpha Plan Prefix list, you'll need your OneHealthPort (OHP) user ID and password.

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ICD-10 FAQ Available on onehealthport.com

A new ICD-10 FAQ recently posted at onehealthport.com was produced by the ICD-10 Work Group, a collaboration of Washington health plans and providers, facilitated by OneHealthPort. The FAQ will be updated on a quarterly basis.

Here are a few sample questions from the FAQ:

Does the ICD-10 mandate apply to paper claims?

ICD-9 codes will no longer be accepted on claims (including electronic and paper) with dates of service (on professional and supplier claims) or dates of discharge/through dates (on institutional claims) on or after Oct. 1, 2014. at:

cms.gov/MLNMattersArticles/Downloads/MM7492.pdf

When will Premera stop accepting ICD-10 codes?

As long as the date of service/discharge is before Oct. 1, 2014, ICD-9 codes will still be valid. Because of claims timely filing limits, appeals, retroactive coverage, and other administrative processes can span the implementation date, the length of time that ICD-9 codes can be accepted will vary by payer.

Find more resources here:

- **cms.gov/MLNMattersArticles/downloads/MM7492.pdf**
- **cms.gov/MLNMattersArticles/downloads/SE0832.pdf**
- **cms.gov/ContractorLearningResources/downloads/JA0832.pdf**

Should we expect updates to the Impairment Group Codes (for Rehab, SNF, etc.), and if so, when?

According to the CMS ICD-10 Impact Analysis, Impairment Group Codes will be translated to ICD-10 which will impact current CMS business processes. No specific dates are indicated for these updates to the Impairment Group Codes. View the complete CMS ICD-10 Impact Analysis at: **cms.gov/Medicare/Coding/ICD10 CMSImplementation-Planning.html**.

Update Your Contact Info

Update your contact information via email at edi@premera.com or call 800-435-2715. Include your phone, TIN, and EDI submitter ID.

2013 Company Closures

Thursday, Nov. 28

Friday, Nov. 29

Tuesday, Dec. 24

Wednesday, Dec. 25

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Electronic Confirmation Reports Help Avoid Lost Claims, Errors

Downloading and reviewing your electronic confirmation reports from your Secure Transport (ST) download directory can help you avoid lost claims and eligibility errors. You can also view rejected claim information. Verifying the reports against your office reports ensures accurate claim tracking.

Here are some key points to remember to effectively use the reports:

- Reports are only available online via ST
- Downloading your reports regularly ensures that we have received your claims and alerts you to claim rejections
- Rejected claims are not processed; they must be corrected and re-billed

Electronic Claims Transaction Reports

The electronic claims transaction report displays all claims that were sent in your 837 electronic claims file. The report is sent on the same business day to your ST Download Directory.

ST users should follow these steps to download response and report files:

1. Go to your download directory
2. Highlight the appropriate report file
3. Select download
4. Access file in the appropriate report directory on your PC

Share the knowledge.

Please post and share this newsletter with co-workers in your office.

Contact EDI

If you have questions or wish to obtain information about any of the articles in this newsletter, please call the EDI Team, 8 a.m.–5 p.m. (PST), Monday through Friday.

800-435-2715

Questions or problems:
You can also email your questions to us at **edi@premera.com.**

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EDI News is a quarterly Premera publication that provides important electronic transaction processing information for office billing staff and software vendors. Please keep this newsletter for future reference. Find archived issues of EDI News at **premera.com/ak/provider**.

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