Chapter 7: Claims & Payments

Coding Types and Sources

Procedure Coding: Procedure coding used for the submission of a healthcare services claim consists of two industry standard coding systems:

- CPT codes: The American Medical Association (AMA) updates and publishes the Current Procedural Terminology annually. The CPT lists descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. CPT Codes provide a uniform language that accurately designates medical, surgical, and diagnostic services—enabling reliable nationwide communication among physicians, patients, and third parties. You can order a CPT book by calling 800-621-8335.
- HCPCS codes: The Centers for Medicare and Medicaid Services (CMS) maintains the Healthcare Common Procedure Coding System. HCPCS codes begin with a single letter (A through V) followed by four numbers. The codes are grouped by the type of service or supply they represent.

When a CPT and a HCPCS code have very similar descriptions for a procedure or service, use the CPT code. If the code descriptions are not identical, select the code with the more specific description that reflects the service rendered.

Diagnosis coding: Select diagnosis coding from the International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM).

Anti-fraud

We abide by federal and state regulations concerning fraud, as well as our contract obligations to members and providers. To support this commitment, we have a Special Investigations Unit to prevent fraud and abuse. If you suspect fraud, call the Anti-Fraud Hotline at 800-848-0244.

Coding

We apply the following claims coding guidelines:

- We use Health Information Portability and Accountability Act (HIPAA) as the benchmark for accepting standard codes
- We accept one primary diagnosis code per line item (CMS-1500 form: box #21)
- Each line item can have a different primary diagnosis or CPT code as long as that diagnosis is included in box #21 of the CMS-1500 form
- We recognize standard modifiers

Because we cannot provide coding advice, we recommend that you maintain current copies of coding reference books or current versions of coding software in your office.

Deleted Codes

We only reimburse current effective procedure codes in the CPT book published by the AMA and HCPCS Codes as maintained by CMS that are effective at the time of service in the year the service was rendered.

If you submit a claim with a deleted code, it will be processed as a denial and the line item will indicate the corresponding denial code. Then you will need to correct the claim to reflect the appropriate code and resubmit the claim as described in "Rebilling" below. Denied claims will be considered a physician or provider write-off until the corrected claim is processed.

New and Established Patient Visits

We use the following definitions established by the AMA and found in the current CPT codebook:

- New patient: A person who has not received any professional service from a physician or other qualified healthcare practitioner or another physician of the same specialty in the same group practice within the past three years.
- Established patient: A person who received professional services from the physician or other qualified healthcare practitioner or another physician of the same specialty in the same group practice within the past three years.

We adopted a policy addressing the use of new and established patient evaluation and management codes. We rely on the physician or other qualified healthcare practitioner to use the code that most accurately reflects the service rendered. We may perform random audits to ensure services are billed appropriately per provider's documentation. As part of the audit process, we may request medical records supporting use of these codes.

Modifiers

The use of modifiers is an important component to coding and billing for services. A modifier is a two-digit character (numeric, alpha numeric, or alpha) designed to provide additional information needed to process a claim. Modifiers allow a provider to identify that a special circumstance has altered a service, but that the basic procedure code description has not changed. Appropriately document the patient's medical record or chart to support the use of any modifier.

Multiple Modifiers

In certain circumstances, multiple modifiers may be necessary to completely describe a service. Our payment system recognizes multiple modifiers to allow you to bill up to four separate modifiers per claim line.

Most Commonly Used Modifiers

We process the following modifiers when appended to an appropriate code(s). Where applicable, the provider's fee schedule allowed amount will be adjusted per any percentage noted:

Code	Brief Description of Modifier	Reimbursement Adjustment Percentage	Applicable Code Categories
22	Increased procedural service	125%	Surgery, radiology, pathology and laboratory, medicine
23	Unusual anesthesia		Anesthesia
24	Unrelated evaluation and management (E/M) service by same physician or other qualified healthcare professional during a postoperative period		E/M
25	Significant, separately identifiable E/M service by the same physician or other qualified healthcare professional on the same day of the procedure or other service		E/M
26	Professional component: for use in reporting when only the professional component of a procedure is provided.		Surgery, radiology, pathology and laboratory, medicine
27*	Multiple outpatient (OP) hospital E/M encounters on same day		E/M
32	Mandated service		E/M, anesthesia, surgery, radiology, pathology and laboratory, medicine
33	Preventive service		E/M, radiology, pathology and laboratory, medicine
47	Anesthesia by surgeon		Surgery
50	Bilateral procedure	150%	Surgery, radiology, medicine
51	Multiple procedures		Surgery, , medicine
52	Reduced services	75%	Surgery, radiology, pathology and laboratory, medicine
53	Discontinued service	33%	Anesthesia, surgery, radiology, medicine
54	Surgical care only	70%	Surgery
55	Postoperative management only	20%	Surgery, medicine
56	Preoperative management only	10%	Surgery, medicine
57	Decision for surgery		E/M
58	Staged or related procedure or service by the same physician or other qualified healthcare professional during the postoperative period		Surgery, radiology, medicine
59	Distinct procedural service		Surgery, radiology, pathology and laboratory, medicine
62	Two surgeons	62.5%	Surgery
63	Procedure performed on infants less than 4kg		Surgery
66	Surgical team		Surgery

Code	Brief Description of Modifier	Reimbursement Adjustment Percentage	Applicable Areas
73*	Discontinued OP/ ambulatory surgery center (ASC procedure) prior to anesthesia administration	50%	Anesthesia, surgery, radiology, pathology and laboratory
74*	Discontinued OP/ASC procedure after administration of anesthesia		Anesthesia, surgery, radiology, pathology and laboratory
76	Repeat procedure by same physician or other qualified healthcare professional		Surgery, radiology, medicine
77	Repeat procedure by another physician or other qualified healthcare professional		Surgery, radiology, medicine
78	Unplanned return to the operating room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period	78%	Surgery, medicine
79	Unrelated procedure or service by the same physician or other qualified healthcare professional during the postoperative period		Surgery, medicine
80	Assistant surgeon	20%	Surgery
81	Minimum assistant surgeon	10%	Surgery
82	Assistant surgeon (when qualified resident surgeon not available)	20%	Surgery
90	Reference (outside) laboratory		Pathology and laboratory
91	Repeat clinical diagnostic laboratory test		Pathology and laboratory
92	Alternative lab platform testing		Pathology and laboratory
99	Multiple modifiers		Surgery, radiology, medicine
AA	Anesthesia performed personally by anesthesiologist		Anesthesia
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures	50%	Anesthesia
AS	Physician assistant (PA), nurse practitioner (NP) or clinical nurse specialist services for assistant-at-surgeon	13%	Surgery
GA	Waiver of Liability Issued as required by Payer Policy		E/M, surgery, radiology, laboratory, medicine, HCPCS
GQ	Telehealth services via asynchronous telecommunications system		E/M, medicine, HCPCS
GT	Telehealth services via interactive audio and video telecommunications systems		E/M, medicine, HCPCS
JW	Drug amount discarded/not administered to any patient		HCPCS, medicine
KX	Requirements specified in the Medical Policy have been met		HCPCS

NR	New Durable Medical Equipment when Rented		HCPCS
NU	New Durable Medical Equipment		HCPCS
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%	Anesthesia
QS	Monitored anesthesia care		Anesthesia
QX	CRNA service with medical direction by a physician	50%	Anesthesia
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	50%	Anesthesia
QZ	CRNA service without medical direction by a physician		Anesthesia
RA	Replacement of Durable Medical Equipment, Orthotic or Prosthetic item		HCPCS
RR	Durable Medical Equipment-Rental		HCPCS
SG	ASC facility service		ASC and Birthing Center services only
SL	State Supplied Vaccine		Medicine
SU	Procedure performed in Physician's Office (facility and equipment)		Surgery, medicine, HCPCS
TC	Technical component: for use in reporting when only the technical component of a procedure is provided.		Radiology, pathology, medicine
TH	Obstetrical treatment/services		E/M
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter		Anesthesia, surgery, radiology, pathology and laboratory, medicine
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner		Anesthesia, surgery, radiology, pathology and laboratory, medicine
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure		Surgery, radiology, medicine
XU	Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service		Surgery, radiology, pathology and laboratory, medicine
Outpatient and ambulatory surgery center use only			

If you have a question regarding a code modifier combination, use the Claims Editor What If Tool under Tools.

Submitting Claims

Member ID Number
When submitting claims, transfer the member's identification (ID) number exactly as it is printed on the ID card, including the leading three-character prefix.

Provider Identification
When completing the CMS-1500 form, note the following:
- Box 25– enter the applicable tax ID number
- Box 31– enter the physician or provider's name that performed the service
- Box 33– enter the "contract name" of physician or provider who performed the service.

National Provider Identifier
HIPAA's Administration Simplification provision requires a standard unique identifier for each covered healthcare provider (those that transmit healthcare information in an electronic form in connection with HIPAA standard claim transactions). The NPI replaces all proprietary (payer-issued) provider identifiers, including Medicare ID numbers (UPINs). It does not replace your tax ID number (TIN) or Drug Enforcement Administration (DEA) number. TINs are still a required element for claims. Electronic claims without a TIN are rejected as incomplete. If you need more information about the NPI mandate, Medicare timelines, and/or the enumeration process, visit the CMS website.

Timely Claims Submission
You can submit claims daily, weekly, or monthly. The earlier you submit claims, the earlier we process them. Ideally, we'd like you to submit claims within 60 calendar days of the covered services, but no later than 365 calendar days. For most plans, we'll deny claims received more than 12 months after the date of service with **no** member responsibility. Refer to your contract for further claims submission information.

Paper Claims
If you are unable to submit claims electronically, you can submit paper claims on CMS-1500 or UB-04 forms. To speed claims processing, we use document imaging and optical character recognition (OCR) equipment to read your claims. To ensure that OCR reads your paper claims accurately:
- Use only red CMS-1500 forms (no photocopied forms)
- Type forms in black ink (handwritten forms cannot be read by OCR equipment)
- Don't fold, staple, or tape your claim
- Be sure information lines up correctly within the respective fields (data that overlaps another field/box cannot be read accurately)
- Don't write or stamp extra information on the form
- Avoid white correction fluid
- Avoid highlighting information

Corrected Claims
Submitting a corrected claim may be necessary when the original claim was submitted with incomplete information (e.g., procedure code, date of service, diagnosis code). The preferred process for submitting corrected claims is to use the 837 transaction (for both professional and facility claims) using claim frequency code 7.

If submitting a corrected claim on paper, remember to:
- Submit as a replacement claim, clearly marking the claim as a corrected claim; failure to indicate that a claim is a "corrected" claim may result in a denial as a duplicate claim
- Bill all original lines—not including all of the original lines will cause the claim to be rejected
- Attach a completed "Corrected Claim – Standard Cover Sheet"

Obtain Corrected Claim – Standard Cover Sheets at onehealthport.com in the administration simplication claims processing section, or under *Forms* on our provider website.

Claims Status
You can obtain the status of a claim:
1. **Online**: The best method to check the status of a claim is to visit our website. Information is available 24 hours a day, seven days a week (see Chapter 2, Online Services, for more information).
2. **Customer Service**: If you don't have Internet access, contact Customer Service by calling 800-722-4714, option 2, or by calling the phone number on back of member's ID card.
3. **Interactive Voice Response (IVR)**: Available 24 hours a day, seven days a week. IVR provides claims information.

Fragmented or Split Professional Billing
A fragmented or split professional billing is defined as professional services rendered by the same provider for the same date of service and submitted on multiple professional claim forms.
- We require all professional services rendered by the same provider for the same date of service, to be submitted on one claim form.
- Exception: When a Medicare patient receives services that Medicare specifically requires to be submitted on separate claim forms.

Claim Suspension and Rejection
Be sure to submit a paper or electronic CMS-1500 claim form that is complete and accurately filled out. Here are common reasons why claims suspend or reject:
- Information doesn't match: Physician/provider information doesn't exactly match what is in our payment system.
- Rebilling: Records are missing when rebilling with a different diagnosis or other change. The claim rejects if records are not attached that support the change.
- Anesthesia: The hours/minutes for anesthesia claims are not included. Anesthesia time is billed in units to represent minutes and additional base units for the code.
- Home IV drugs: Missing NDC number and quantity.
- Advanced registered nurse practitioner: Supervising physician's name is missing for non-credentialed and/or not contracted ARNP.
- PAs: Supervising physician's name is missing for PA (***Note***: A PA does not need to bill with a supervising physician if he/she is a Surgical Assistant and has completed the paperwork to be set up independently in our payment systems).
- Codes: Using invalid CPT/HCPCS, modifiers, or diagnosis codes.
- Onset date: Missing from box 14 in the CMS-1500 claim form.
- Incorrect member number: Provider billing with member's social security number (SSN) instead of the non-SSN member identification number on their card.

Payment Questions
Contact Customer Service with questions regarding claims processing, or send a copy of the voucher highlighting the claim in question and the inquiry reason. If we processed the original claim incorrectly, you do not need to rebill. The claim will be reprocessed and reflected on the payment voucher. You can reach Customer Service by calling 800-722-4714, option 2, or by calling the Customer Service phone number on the back of the member's ID card. Before discussing member claim information, the Customer Service representative must verify the identity of the caller.

Reimbursement

Usual, customary, and reasonable

We generally use a usual, customary, and reasonable (UCR) payment methodology of the 80th percentile of billed charges for each CPT code. This generally applies to professional claims for commercial products and Federal Employee Program (FEP).

Details of our UCR reimbursement are:

- <u>CPT codes with five or more claims within each geographical region of the state</u>: We reimburse all surgical and non-surgical codes based on the provider's billed charges or the 80th percentile of billed charges *in that region* (whichever is lower).
- <u>CPT codes with fewer than five claims within each specific region</u>: We reimburse all surgical and non-surgical codes based on the provider's billed charges or the 80th percentile of billed charges *statewide* (whichever is lower).
- <u>CPT codes with fewer than five claims within the state</u>: The rate is established at the greater of 150% of the 80th percentile conversion factor for the service category multiplied by the code's resource-based relative value scale (RBRVS) weight and 250% of the Alaska Medicare rate.

Resource-Based Relative Value Scale

In some contracts, we use a RBRVS methodology, developed by CMS, to calculate its fee-for-service fee schedule. RBRVS is a method of reimbursement that determines allowable fee amounts based on established unit values as set norms for various medical and surgical procedures, and further based on weights assigned to each procedure code (see below). These weights are then multiplied by the dollar conversion factor we publish. The conversion factor represents the dollar value of each relative value unit (RVU). When the conversion factor is multiplied by the total RVUs, it will yield the reimbursement rate for the specific service (or code).

There are three separate components that affect the value of each medical service or procedure:

- *Physician work* – the work value reflects the cost of the physician's time and skill for each service.
- *Practice expense* – the physician's direct (non-physician labor, medical equipment, medical supplies) and indirect (general office supplies, rent, utilities, office overhead) costs related to each service.
- *Malpractice insurance* – the malpractice insurance component.

RVUs are assigned to each of these components. CMS also uses RVUs to allocate dollar values to each CPT or HCPCS code. For more information about RBRVS methodology visit the CMS website at cms.gov/physicianfeesched.

For services not listed in the RBRVS published annually in the Federal Register, we use Optum's Essential RBRVS (previously known as Ingenix Essential RBRVS and St. Anthony's Complete RBRVS).

Claims Adjudication System

We use an automated processing system to adjudicate claims. When processing claims, the system:

- Checks for eligibility of the member listed on the claim
- Checks for completeness of the claim
- Confirms the accuracy of the information
- Compares the services provided on the claim to the benefits in the subscriber's contract
- Applies industry standard claim edits and applicable payment policy criteria
- Concludes the payment amount

Actual payment is subject to our fee schedule and payment policies, a member's eligibility, coverage, benefit limits at the time of service, and claims adjudication edits common to the industry.

Claims Editing Software
We regularly update (at least quarterly) our claims editing software to keep pace with changes in medical technology, as well as CPT codes, HCPCS codes, and ICD-10-CM/PCS Diagnosis and Procedure code changes, standards, and complexities. This software evaluates billing information and coding accuracy on submitted claims and assists in achieving consistent, accurate, and timely processing of physician and provider payments.

Our Claims Editor What If Tool allows you to enter a combination of codes that you may wish to bill and receive an informational description of how our claims editing software generally edits the code combination submitted. The description provided by the What If Tool is based solely on the information provided and does not take into account any other information such as claims history, eligibility, benefit, pricing deductible or other member or group specific information. In addition, use of the What If Tool is not a guarantee of payment.

Payment Policy
Our Provider Billing Integrity Oversight Committee reviews proposals for new payment policies and updates to our policies. Physicians and providers may submit a proposal to modify a payment policy. To do so, please submit the proposal in writing to your assigned Provider Network Executive (PNE) or Provider Network Associate (PNA).

We follow industry standard coding recommendations and guidelines from sources such as the CMS, CPT, and AMA, and other professional organizations and medical societies and colleges. National Correct Coding Initiative (NCCI) editing is followed when applicable. Any exceptions are documented as Payment Policies. It is only after we determine a member's eligibility or coverage that payment policy applies. Payment policy:
- Applies to professional claims, including some facility claims specific to serious adverse events or present on admission issues.
- Does not determine the reimbursement dollar amount for any particular service (reimbursement is specific to the fee schedule).
- Is distinct from our medical policy, which sets forth whether a procedure is investigational or experimental and whether treatment is appropriate for the condition treated.

You can find our payment policies on our website in the Library, under *Reference Info*. Always refer to the online versions of our payment policies to ensure to most current and accurate information.

Overpayments
Calypso, our affiliate, processes refunds and overpayment requests. When Calypso identifies an overpayment, they mail an Overpayment Notification letter with a request for the overpaid amount.

Sometimes an office returns a check to us that represents multiple claims because a *portion* (see "Threshold" below) of the payment may be incorrect. In these cases, please **do not return the check to us**. Instead, deposit the check, circle the claim in question on the Explanation of Payment (EOP) and include a short explanation as to why there was an overpayment. After these steps are completed, you can choose **one** of the following options to resolve the overpayment:

- Mail the overpayment amount to our finance department (address on check) along with a completed Refund Request form, or
- Mail a completed Overpayment Notification form (found in our online library under "Forms") and mark the box requesting a voucher deduction to recover the overpayment on future claim payments.

Calypso will apply the refund to the claim as soon as they receive the refund. If you require a written refund request before mailing the overpayment, contact Calypso directly at 800-364-2991.

We do not request refunds for overpayments less than $25, but you may submit these voluntarily. (BlueCard will request refunds regardless of the dollar amount.) Refund total overpayment amounts within 60 days of initial notice to avoid having outstanding refund amounts offset against future payments.

Prompt Pay Standards
We process your claims as soon as we receive them. We also apply the following Prompt Pay standards set by Alaska's Division of Insurance to our claims adjudication process in order to:
- Pay or deny 95% of a provider's monthly clean claims within 30 days of receipt; and
- Pay or deny 95% of a provider's monthly volume of all claims within 60 days of receipt.

If the above standards are met, the regulation does not require interest for those individual claims paid outside of the 95% threshold.

Clean Claim Definition
A clean claim is one that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. This includes any missing required substantiating documentation or particular circumstances requiring special treatment.

Clean Claim Exclusions
Claims may also be delayed during processing if:
- They are suspended due to the group or individual's non-payment of premium or dues
- They have Coordination of Benefits when we are the secondary carrier on the claim
- They require completion and mailing of an Incident Questionnaire for possible accident investigation or a Workers Compensation injury (claims in subrogation)
- They include a request of medical records for review

Applying Interest
If we fail to satisfy any of the above standards, commencing on the 31st day, we will pay interest at a 15% annual rate on the unpaid or un-denied clean claim. Interest will not be calculated on unclean claims regardless of how long it takes to process them.

Interest Vouchers
Prompt Pay interest is currently calculated monthly for the previous month's paid claims. Payments are issued under a separate voucher and mailed to the address on the original claim. Included with the interest voucher is a summary report detailing the claims for which interest payments have been applied during that period.

Interest Threshold
There is a minimum threshold of $25 for monthly interest payments on delayed clean claims. An interest check is issued only for months in which the accumulated interest is equal to or greater than the minimum threshold of $25. Interest less than $25 will continue to accrue until it reaches that threshold or until December of each year. To help your office complete yearend accounting, each December we'll issue you a check for the accrued interest we owe you, even if the amount is below the threshold.

Prompt Pay Unit
Contact the Prompt Pay Unit at 800-932-2883 for inquiries regarding the following:
- Voucher-related interest payments
- Application of interest payments
- Amount of interest paid
- Lack of interest payment

Special Billing Situations
After-Hours Services
After-hours services (codes 99050 through 99060) are provided in the physician or provider's office outside posted office hours, on Sundays, or on holidays. We do not reimburse these codes, unless provider contract terms specifically include and allow reimbursement. These codes are Medicare Status B codes and are included in the allowance of another service(s).

Anesthesia Services
We use American Society of Anesthesiologists (ASA) codes (codes 00100-01999) to establish anesthesia base units. Use only ASA codes when billing anesthesia. Please note the following:
- **Anesthesia Modifiers:** We require that the appropriate anesthesia modifier (modifiers AA, AD, QK, QX, QY, or QZ) be added to all anesthesia codes to identify the level of the provider rendering the service (e.g. Certified Registered Nurse Anesthetist, Resident Physician, supervising or directing Physician Anesthesiologist). Anesthesia codes submitted without an anesthesia modifier will be denied reimbursement.
- **Physical status modifiers**: Additional time units are added for physical status modifiers P1-P6, based on the guidelines published annually in the ASA Relative Value Guide.
- **ASA codes 99100-99140** (Qualifying Circumstance codes): These codes are Medicare Status B services and are not be eligible for reimbursement.
- **ASA add-on codes**: These codes are reimbursed based on guidelines published annually in the Relative Value Guide from the ASA and must be billed in conjunction with the base anesthesia code
- **Obstetrical anesthesia**: We allow standard base units for obstetrical delivery of epidural anesthesia.
- **Labor management anesthesia**: We allow three "time units" for labor management for the initial hour and two "time units" for each additional hour.
- **Conversion of time to units**: Anesthesia units are calculated based on a four-unit hour. We convert reported anesthesia time to units by dividing the total anesthesia minutes reported by 15 and standard rounding to the nearest hundredth decimal point (example: 4.33).
- **Nerve blocks**: We reimburse nerve blocks based on Relative Value Units only.

Blood Draw
We limit blood draws (36415) to one per provider, per patient, per day. We will deny CPT code 36416 as a Medicare Status B code.

Hospital Outpatient Facility Services
All hospital outpatient facility services billed with revenue codes 0760 – 0769 (outpatient treatment/observation room) are processed subject to the hospital outpatient facility medical benefit cost shares. You must bill hospital outpatient facility surgical services with revenue codes 0360, 0361, 0369, 0490-0499 or 0750 and the appropriate surgical CPT procedure code in order to be subject to the hospital outpatient facility surgical benefit cost shares.

Multiple Births
Twins – Both Vaginal or One Vaginal and One Cesarean: We will reimburse one global obstetric birthing procedure (routine prenatal obstetric care, delivery and postpartum care) for the first birth and one delivery-only procedure for the second birth. Please note that the level of reimbursement is subject to our payment policy on multiple procedures.

Example 1:
59400 – allowed at 100%

Example 2:
59400 – allowed at 100%
59514-59 – allowed at 50%
59409-59 – allowed at 50%

<u>Twins – Both Cesarean</u>: We reimburse either one global obstetric birthing procedure (routine prenatal obstetric care, delivery and post-partum care) or one delivery-only procedure, whichever is appropriate.

Example :
59510 – allowed at 100%
59514-59 – no additional reimbursement

<u>Triplets, Quadruplets, etc. – All Cesarean</u>: We reimburse one global obstetric birthing procedure (routine prenatal obstetric care, delivery and post-partum care).

Example :
59510 – allowed at 100%
59514-59 – no additional reimbursement
59514-59 – no additional reimbursement

Bill the delivery of each baby on a separate line on the claim. Each subsequent birth after the initial birth should be billed with modifier 59-Distinct Procedural Service in order to prevent an edit indicating a duplicate service.

Osteopathic Manipulation
Osteopathic manipulation is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. Please note the following:
- Osteopathic manipulation code billed with a new patient E/M code: both allowed at 100% of the allowable charge.
- Osteopathic manipulation code billed with an established patient E/M code: only the manipulation is allowed at 100% of the allowable charge. If the E/M service is separate and distinct from the manipulation, the E/M should be reported with a modifier 25. Documentation in the member's medical record must support that the evaluation and management services was truly distinct and separate from the surgical procedure performed.
- Only one osteopathic manipulation code (codes 98925 – 98929), per day, per member is allowed.
- Physical therapy service codes billed with an osteopathic manipulation code will allow each service: both allowed at 100% of the allowable charge. Reimbursement of multiple physical therapy services is consistent with our policy on physical therapy services limits.

Preoperative Period
Evaluation and management services provided the date before or on the date of a major surgical procedure will be considered part of the global surgery reimbursement and are not eligible for separate reimbursement. If the visit resulted in the initial decision to perform surgery separate reimbursement will be allowed for the evaluation and management service when appended with
Modifier 57.

For significant, separately identifiable and documented E/M services billed on the same day as a surgical procedure, use modifier 25 on the evaluation and management service to indicate the service was a distinct procedural service from the surgical procedure. Documentation in the member's medical record

must support that the evaluation and management services was truly distinct and separate from the surgical procedure performed.

Screening Pap Smear
We will allow separate reimbursement for an E/M service as a visit on the same day as a screening Pap smear (Q0091) when the E/M visit is a separate and distinct service from the Pap smear and is reported with modifier 25. Documentation in the member's medical record must support that the evaluation and management services was truly distinct and separate from the procedure performed. Separate reimbursement is not allowed for a screening Pap smear (Q0091) when performed on the same day as a preventive medicine examination or annual gynecological examination.

Telehealth
Telehealth services are described as medical information exchanged from one site to another via electronic modes of communication between a practitioner and patient in a manner other than an in office face-to-face encounter. Such services can be delivered via:

- **Real-Time or Near Real-Time Interactive or Synchronous** technology which include systems that transmit interactive audio and video information and permit two-way, real-time communication instantly or with very little or no noticeable delay. The patient must be present and participating in the telehealth visit (Example: a videoconference).
- **Store-and-Forward or Asynchronous** technology uses high-resolution video and high-fidelity audio to transmit information that will be stored and sent to a practitioner in a distant site for interpretation at a later time. The patient is not present and is not participating in the visit. **Asynchronous** communications do not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (email).
- **Telephone Assessment and Management** are a non-face to face E/M provided to a patient using a telephone by a physician or other non-physician healthcare professional who may report E/M services. The encounter is the equivalent of a low-level office visit with all of the same history, exam and medical decision making criteria documented in the member's medical record. Such encounters are not used for renewing prescriptions or triaging a patient in order to set up an office visit within 24 hours.
- **Online/Internet Communications** are a non-face to face E/M provided by a physician or other qualified non-physician healthcare professional who may report E/M services using a secure and encrypted Internet resource in response to a patient's online inquiry. Such encounters include all of the provider's personal time in response to the patient and involve permanent storage (electronic or hard copy) of the encounter. This encounter is the equivalent of a low level office visit with all of the same history, exam and medical decision making criteria documented in the member's medical record.

Synchronous and Asynchronous technology requires specifying both an "originating site" and a "distant site." These are defined as follows:
- **Distant site**: The location from which the physician or practitioner providing the professional medical service is located at the time the telehealth service is provided.
- **Originating site**: The location of the insured patient at the time the telehealth service is performed.

Note the following:
- We recognize the use of synchronous or asynchronous communications substituted for a face-to-face, hands-on encounter for consultation services, office visits, individual psychotherapy services, and pharmacologic management services when appended with the appropriate modifier.
- We require modifiers GQ-Via asynchronous telecommunications system or GT-Via interactive audio and video telecommunication systems to be used to indicate that the services were

provided using a telecommunications system. By using one of these modifiers, the distant site practitioner verifies that the patient was located at an eligible originating site at the time of the telehealth service.

- We recognize HCPCS Code Q3014-Telehealth originating site facility fee (without any modifier) as the code designated to indicate the originating facility fee.
- We require documentation in the member's record to support any encounter conducted as a synchronous office visit, a telephone assessment or an online/internet communication and that it be made available for review in the event of an audit

Treating Self and Family Members
We do not reimburse for professional services or supplies that are usually provided free because of the relationship to the patient.

As a reminder, physicians, providers or suppliers who are our members are **not** reimbursed by us for professional services for any of the following when services are

- Performed on themselves
- Rendered to family members residing in the home
- Provided to the following immediate relatives: spouse, natural or adoptive parent, child, sibling, stepparent, stepchild, stepsibling, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild, spouse of grandparent, or spouse of a grandchild

Locum Tenens
A *locum tenens* physician does not need to be credentialed because he/she is considered a temporary provider; however, if a *locum tenens* physician provides services for more than 90 days, he/she must be credentialed. A *locum tenens* physician bills under the name of the absent, contracted physician.

Surgical Assistance Modifiers
We have payment policies that define how to use Modifiers –80, –81, –82 and –AS to indicate when surgical assistance is provided to a primary surgeon. Bill all surgical assistance services under the name of the performing provider or the person who assisted the primary surgeon. Bill the charges for the primary surgeon and the assisting surgeon separate claims—never on the same claims under the same provider name.

Definitions and Billing Guidelines:
Modifier –80, Assistant Surgeon. This modifier indicates that the assisting surgeon is actively assisting a primary surgeon. Add Modifier –80 to the surgical procedure to identify surgical assistant services when appropriate. Only one physician may assist another physician in performing a procedure. If an assistant surgeon assists a primary surgeon and is present for the entire operation, then the assisting physician reports the same surgical procedure as the primary surgeon with Modifier –80 appended.
Modifier –81, Minimum Assistant Surgeon. This modifier is used when the surgical assistant does not participate in the entire surgical procedure. Add Modifier –81 to the surgical procedure to identify minimum surgical assistant services when appropriate. There are times when a primary operating physician may plan to perform a surgical procedure alone, but during the operation, circumstances may require surgical assistance for a relatively short time. In this instance, the second surgeon provides minimal assistance, for which he/she reports the same surgical procedure as the operating surgeon with Modifier –81 appended.
Modifier –82, Assistant Surgeon (when qualified resident surgeon is not available). The prerequisite for adding Modifier –82 to the surgical procedure is the unavailability of a qualified resident surgeon. In certain programs (e.g., teaching hospital), the physician acting as the assistant surgeon is usually a qualified resident surgeon. However, there may be times (e.g., during rotation change) when a qualified resident surgeon is not available and another surgeon assists in the operation. In this instance, the services of the nonresident-assistant surgeon should be reported with Modifier –82 appended to the

appropriate code to show that another surgeon assisted the operating surgeon instead of a qualified resident surgeon.

Modifier –AS. PA, NP, or clinical nurse specialist services for assistant at surgery. This modifier is used when a "non-physician" provider assists the primary surgeon. Use this modifier when a PA, NP, or clinical nurse specialist provides surgical assistance. Add the HCPCS modifier –AS to the same surgical procedure code as the primary surgeon.

Special Situations

An ARNP or NP provides services to members via <u>one</u> of the following methods:
- Clinic practice: bills under the name of a contracted, supervising physician—credentialing not required (a clinic can be one or more physicians)
- Solo ARNP: bills under his/her own name (credentialing required)
- Surgical assistant ARNP: bills under his/her own name (must complete a Data Request form prior to performing services)

A PA provides services to members via <u>one</u> of the following methods:
- Clinic practice: bills under the name of a contracted, supervising physician—credentialing not applicable to Pas (a clinic can be one or more physicians)
- Surgical assistant PA: bills under his/her own name (must complete a Data Request form prior to performing services is required).

Add-On Codes

Some procedures in the CPT codebook are performed in addition to a primary service code. These services are notated as an add-on code by the symbol " + " in the codebook and are listed in Appendix D of the CPT Codebook. Add-on codes are always performed in conjunction with a primary code/procedure. Instructions identifying the correct primary code are listed after the add-on code in the CPT codebook. Add-on codes billed without a primary code or billed with an incorrect primary procedure code will encounter an edit and possible denial of reimbursement.

Unlisted Procedures

Healthcare professionals may render procedures and services for which there is no specific CPT or HCPCS code available. Providers may use unlisted codes, unspecified codes, or miscellaneous codes, which usually end in XXX99. These codes do not have specific language that describes the particular service. These codes should only be used as a last resort if there is not a more specific CPT or HCPCS code available.

We require that you submit supporting detailed documentation with claims to describe the service(s) rendered, identifying what was performed as part of the service. Critical documentation should include:
- A clear description of the service performed
- Identification as to whether the service performed was independent form other services performed at the same time
- Any extenuating circumstances which may have complicated the service
- Time, effort and equipment necessary to provide the service, and
- Number of times this service has been performed

Failure to provide such detailed information may result in a delay or denial of the claim being processed.

Medicare Status B Codes

In the National Physician Fee Schedule (NPFS), as maintained by CMS, procedure codes that are identified with a Status Indicator code of "B" are not eligible for reimbursement, whether billed alone or with another service, and will be denied. To obtain a complete list of Status B codes, visit the <u>CMS website and select the most current NPFS release.</u>

Prolonged Services for Labor Management

We restrict the use of these prolonged service codes in maternity care. Reimbursement is not separately provided when prolonged service codes are billed to indicate the management of labor, which is considered a component of the delivery care.

Prolonged services for both outpatient and inpatient care are billed using the following codes:
- +99354 – Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management service)
- +99355 – each additional 30 minutes (List separately in addition to code for prolonged service)
- +99356 – Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient Evaluation and Management service)
- +99357 – each additional 30 minutes (List separately in addition to code for prolonged service)

"+" denotes an add-on code

Global Surgery

Global surgery or global surgical package is a period of time that starts either with the day of or the day before the surgical procedure and ends some timeframe after the surgical procedure based on whether the procedure is classified as minor or major surgery.

We use the global surgery indicator flag as established in the current version of the National Physician Fee Schedule (NPFS), maintained by CMS, to determine whether a procedure code does/does not have a specified global surgery period (e.g., simple/minor procedures, minor surgical procedures, major surgical procedures, maternity codes, global periods to not apply, carrier/plan determined or add-on codes).

Robotic Surgery and Computer-Assisted Navigation

Robotic surgery and computer-assisted navigation services are add-on techniques used to perform the main surgical procedure. As such, when these add-on codes are billed , the robotic surgical system code and the computer-assisted navigation codes will be considered bundled/included as part of the primary surgical procedure and not separately reimbursable, whether billed separately or in conjunction with a primary procedure.

Robotic surgical system services and computer-assisted navigation for musculoskeletal surgical services are billed using the following HCPCS or CPT codes:
- +S2900 – Surgical techniques requiring use of robotic surgical system (list separately in addition to code for primary procedure)
- +20985 – Computer assisted surgical navigational procedure for musculoskeletal procedures, image-less (List separately in addition to code for primary procedure)
- +0054T – Computer assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on fluoroscopic images (List separately in addition to code for primary procedure)
- +0055T – Computer assisted musculoskeletal surgical navigational orthopedic procedure, with image guidance based on CT/MRI images (List separately in addition to code for primary procedure)

   "+"denotes an add-on code which must be billed with an appropriate primary procedure

Discarded Drugs/Non-Administered Drugs – Modifier JW

When administering drugs from a single use vial or package, a leftover portion of the drug that was not administered to a patient can be submitted for reimbursement along with the administered portion of the drug.

Submit two lines with the same HCPCS or CPT code, one line with the modifier JW to represent the non-administered portion and the other line without the modifier to represent the administered portion. Units on each line should represent the portions administered and the portion non-administered or wasted.

Durable Medical Equipment (DME) and Home Medical Equipment (HME) Rental to Purchase
Modifiers are required on any piece of DME that can be rented to own, whether that is a daily rental, a monthly rental or a continuous rental of the equipment. Add one of the following modifiers to reflect whether the equipment is either a purchased, replacement or rented piece of equipment:
- Purchase modifiers
  - NU – new equipment
  - NR – new when rented (Use when DME that was new when first rented is later purchased. Bill the purchase price of the equipment)
  - RA – replacement of a DME, orthotic or prosthetic item
  - UE – used DME
- Rental modifiers
  - RR – rental
  - LL – Lease/rental
  - KR – rental item for a partial month (use to indicate daily rentals)

Units of service must also match the type of DME rental in order to be correctly reimbursed:
- Monthly rentals
  - One month of rental equals one unit when modifier RR is added
  - Each month should be billed on a single claim line (i.e. 1 service month rather than 30 units of service)
- Daily rentals
  - One day of rental equals one unit when modifier KR is appended
  - "From" and "Through" dates of service must match the number of unit billed
  - Future dates of service will not be accepted; submit claims after the end of the rental period

Explanation of Payment

Physicians and other healthcare providers receive an Explanation of Payment (EOP), which describes our determination of the payment for services. See the following pages for an explanation of the EOP fields and a description of codes and messages.

PREMERA | Blue Cross Blue Shield
BLUE CROSS BLUE SHIELD OF ALASKA

PO Box 91059
Seattle, WA 98111

Page Number 1- 1
Date of Payment: April 30, 2010
Check Number: 1234567890
Payment Reference #: 1234567890123456
Provider Number: 123456789012
Provider Tax ID Number: 123456789

Medical Clinic
1616 Fourth Avenue
Anchorage, AK 99504

April 30, 2010

DETAILED EXPLANATION OF PAYMENT

(A) Patient Name Subscriber # & PT Suffix Patient Account # Subscriber Name Claim # Provider Of Service / Product	(B) SERVICE DATES	(C) CODE / MODIFIER	(D) UNITS BILLED / ALLOWED	(E) APC/ APG / DRG / ROOM TYPE	(F) BILLED CHARGES	INFORMATIONAL (G) ALLOWED AMOUNT	PROVIDER (H) ADJUSTMENT (A) DISALLOWED (D)	(I) OTHER INSURANCE ADJUSTMENT	PATIENT LIABILITY FEE ADJUST (A) COB SAV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)	(K) PAYABLE AMOUNT	(L) REASON REMARKS
Finley, B	41210 41210	99275	1/1	C6	205.00	178.00	27.00 A	0.00	0.00	178.00	PSS
ABC 100000000-00	41610 41610	70010	1/1		90.00	67.00	23.00 A	0.00	14.00 C	53.00	PSS
01053											
Finley, B	**Claim Total**		**Paid To: P**		**$295.00**	**$245.00**	**$50.00**	**$0.00**	**$14.00**	**$231.00***	
020040001600											
Medical Clinic											
Heritage											

VOUCHER TOTAL	$295.00	$245.00	$50.00	$0.00	$14.00	$231.00

LESS PAID TO CODES LISTED AS "S" OR "C" $14.00
TOTAL RECOVERED THIS PAYMENT CYCLE $177.34
TOTAL PAYABLE AMOUNT $53.66

Our records indicate your current Tax ID as being   999999999

Reason Remarks Explanation
PSS   CHARGES EXCEED THE CONTRACTED AMOUNT FOR THIS SERVICE

	Field Name	**Description**
A	Patient Name	Patient/member name.
	Subscriber Number and Pt Suffix	Subscriber's number and patient suffix number (including alpha prefix) assigned by plan as shown on the member's identification card.
	Patient Account Number	Number assigned by the clinic for patient. (If no account number is assigned, the words "No Patient Account #" are noted.)
	Subscriber Name	Name of the subscriber.
	Claim Number	Number assigned to the claim when received by plan.
	Provider of Service	Provider who rendered the service. Professional example: GENERAL CLINIC is the provider of service.
B	Service Dates	The dates-of-service (to and from - also referred to as beginning and ending dates) at a **line item level**.
C	Code/Modifier	The code/modifier shown in box 24D of the CMS-1500.
D	Units Billed/Allowed and Paid to	Units shown in box 24G of the CMS-1500 form. "Paid to" refers to the payee code (where the check was sent/issued) and is listed only in the claim total or subtotal line (e.g., G = Provider Group).
E	APG/DRG/Room Type	Applicable to facility claims only – reflects the APG code, DRG code, or room type that may relate to the reimbursement amounts. (Field not populated for CMS-1500 claims.)
F	Billed Charges	Charges billed by physician/provider at a line item level.
G	Allowed Amount	Amount allowed for service at a line item level.
H	Provider Adjustment	"Provider write-off" amount.
I	Other Insurance	Amount paid by other carrier(s).
J	Patient Liability	**Total patient liability:** Amount owed by patient. Patient liability is deductible and copay/coinsurance and ineligible amounts rolled up. • **FEE ADJUST (A)** = Member responsibility per subscriber contract. • **COB SAV APP (B)** = Amount applied from member's COB saving account. • **COINSURANCE (C)** = A predetermined amount designated by the subscriber's plan. Applies after the patient meets his/her deductible. • **DEDUCTIBLE (D)** = A predetermined amount designated by the subscriber's plan, must be satisfied by member before benefits apply. • **INELIGIBLE (I)** = Services that the member does not have a benefit predetermined by the plan. • **COPAY (P)** = Amount member is responsible to pay at time of service (e.g., $20 office visit copay).
K	Payable Amount	Amount payable by plan.
L	Reason remark	Adjudication explanation code(s) at a line item level and claim level (if applicable).
M	Claim Total	Printed at the end of each claim, the line items are summed and an asterisk indicates the claim total line.
N	Paid To	Indicates the claim payment recipient.
O	Less "Paid to" Codes Listed as "S" or "C"	The sum of the claim total "Payable Amounts" which have a "PD TO" code of S or C.
P	Total Recovered This Payment Cycle	The sum of any amount withheld and applied to a prior refund or recovery.
Q	Total Payable Amount	Indicates the amount of the check.

Codes and Messages

The most commonly occurring codes and messages are listed below. A comprehensive list is posted in the Library under *Reference Info.*

EOP Code	Printed Message
202	A required waiting period must pass before we can provide benefits for this service.
318	We forwarded this claim to the member's home plan for processing.
401	Our medical staff reviewed this claim and determined that this admission doesn't meet the criteria for medical necessity.
402	Our medical staff reviewed this claim and determined that this continued stay doesn't meet the criteria for medical necessity.
403	Our medical staff reviewed this claim and determined that this service isn't covered by the plan.
406	Payment of this claim depended on our review of information from the provider. We haven't received the information.
453	We can't process this claim until the incident questionnaire we sent the member is fully completed, signed and returned.
466	This is a claim adjustment of a previously processed claim.
473	Need information from the member's other insurance carrier to process claim. Send us other carrier's explanation of benefits.
474	The provider needs to submit itemized charges to us.
480	We can't process this claim until the questionnaire we recently sent the member is completed and returned to us.
487	To pay this claim, we needed to review information from the provider. We haven't received the information.
497	This is a duplicate of a previously denied claim.
498	This claim was paid previously to the provider or applied to the member's deductible.
500	This member wasn't eligible for services on the date of service.
550	This member wasn't eligible for services on the date of service.
551	The maximum limit has been met for this benefit.
575	This procedure is considered cosmetic. The plan doesn't cover cosmetic services.
578	The plan doesn't cover this service.
581	This service is considered a standard exclusion.
741	The charges for this service have been combined into the primary procedure based on the provider's contract.
763	These charges are included in the main anesthesia service.
800	We can't process this claim because we haven't received the necessary information we requested from your provider.
801	We can't process this claim because we haven't received your response to our request for information.
840	This claim is a duplicate of a previously submitted claim for this member.
844	Provider: send us the member's medical records for this claim. We can process the claim after we receive that information.
845	Provider: please send us your office notes for this claim. We can process the claim after we receive that information.
846	Provider: please send us your operative notes for this claim. We can process the claim after we receive that information.
847	Provider: please send us the member's lab results for this claim. We can process the claim after we receive that information.
848	Provider: please send us the radiology reports for this claim. We can process the claim after we receive that information.
876	Provider: send us the NDC #, quantity and date span for this claim. We can process the claim after we receive that information.
877	Provider: send us medical records relating to prescription drug charges. We'll process the claim after we receive that information.

Statement of Overpayment Recoveries

A SORA is included with an Explanation of Payment (EOP) when we've processed an overpayment recovery activity within a payment cycle. The SORA is generated when one of the following occurs during a payment cycle:

- An amount is deducted from your check
- An overpayment was recorded during the payment cycle
- There is a balance due to us at the end of the payment cycle
- Money was posted to your account during the payment cycle
- When there is any other activity on your account during the payment cycle

	Field Name	Description
A	Patient Name	Patient (member) name.
	Subscriber # and PT Suffix	Subscriber's number and patient suffix number (including alpha prefix) we assign.
	Patient Account #	Patient number assigned by the provider/clinic/hospital. (If no account number is assigned, the words "No Patient Account #" are noted.)
	Subscriber Name	Subscriber's name.
	Claim Number	Claim number associated with the overpayment.
	Claim Date Span	Date span of the claim. (The span will be the first through the last date of service on the claim.)
	Provider of Service	Provider who rendered the service.
B	Payment Reference ID	This number specifies the current and/or prior payment vouchers applied towards the overpayment. (Each SORA has its own payment reference ID which is located in the upper right-hand corner.)
C	Payment Cycle Date	Date of payment shown in the system that relates to the Payment Reference ID.
D	Prior Payment Cycle	Original overpayment amount from prior statements (prints until balance is zero).
E	This Payment Cycle	Overpayment amount that applied to this payment cycle.
F	Payment From Provider	Amount(s) the provider voluntarily paid toward the overpayment balance.
G	Prior Payment Cycle	Amount recovered from prior payment cycles.
H	This Payment Cycle	Amount recovered from current payment cycle.
I	Outstanding Over-Payment	Balance of overpayments not recovered.
J	Overpayment Totals	Total amount for each column in the statement.
K	Total Recovered This Payment Cycle	Total overpayments recovered in the current payment cycle.

CMS-1500 Form Completion

If you are a hospital-based physician or provider, use a [CMS-1500 (02-12) form](#) for claims for professional services and supplies related to:

- Anesthesia
- Consultations
- Day surgery/professional
- Emergency physician services
- Mental health
- Obstetrics
- Occupational therapy
- Pathology/interpretation
- Physical therapy
- Radiology/interpretation
- Speech therapy

This includes claims for outpatient services and services performed by a hospital-based physician or other provider.

Patient Account Numbers Assigned by Your Office

Many offices assign their own account numbers to patients. To make tracking patient reimbursement easier, we can include these account numbers on our payment vouchers. Your account number can be included in box 26 (Patient's Account Number) of the CMS-1500 form whether you submit electronically or on paper. Please note that some processing systems may have a limitation regarding the number of characters recognized.

Guidelines

The National Uniform Claim Committee (NUCC) has developed a [1500 Reference Instruction Manual](#) detailing how to complete the claim form to help nationally standardize how the form is completed. Please refer to your electronic billing manual for specific formatting for electronic claims.

Electronic Claims Submission

Our electronic claims process electronically separates and routes only valid claims for processing. Invalid claims are reported back to the provider with rejection details. There is no charge to healthcare providers who submit electronic claims directly to us.

If you submit your claims electronically, you may receive electronic remittance for the following:

- Premera Blue Cross Blue Shield of Alaska Participating (Traditional/Indemnity) and Preferred/BestCare (PPO)
- Premera Dental
- FEP
- National Account Service Company (NASCO)
- BlueCard (Out of area)
- Dimensions (HeritagePlus, HeritageSelect, or Global)

Advantages

Submit claims electronically for:

- Faster claims payment turnaround
- Less time spent on claims preparation
- Validation to ensure that they are HIPAA-compliant
- Detailed claim acceptance and rejection reporting

Remittance is available online—just let us know. Your office staff can then post this remittance manually or electronically (if your software has electronic posting capability).

We accept FEP professional medical claims from all providers in Alaska. For additional information, contact an EDI representative at 800-435-2715).

Getting Started
To help you move from paper to electronic claims, follow these steps:
1. If you are interested in purchasing a new computer system, ask us for a list of vendors that submit claims to us in the HIPAA standard ANSI 837 format.
2. If you already have a computer system, notify your software vendor of your desire to convert to electronic claims. You will need special software to send insurance claims electronically.
3. Call EDI at 800-435-2715 for information. They will send you the following documents:
   - EDI Enrollment Information
   - Secure Transport (ST) User Guide
   - Testing process information
4. Your software vendor can help you set up your computer to accommodate Premera's billing requirements.
5. Plan to submit test claims. Continue to submit paper claims until you are told to stop. **We review test claims for accuracy, but do not process them for payment**.
6. An EDI representative will review the test claims with you or your vendor. We will notify you in writing or by telephone when you have successfully completed the test phase. When this notification has occurred, change the indicator on your claims from **(T)**est to **(P)**roduction and begin submitting live electronic claims. At that time, please discontinue submitting paper claims.

Submitting Secondary Claims Electronically
Electronic claims can be sent when we are the secondary insurance payer. If you bill your claims using the ANSI 837 electronic format, then you must include the Coordination of Benefits (COB) information from the primary coverage payer in your claim. COB information is allowed when the primary coverage is with a commercial payer; this generally excludes Medicare and FEP. If you are unsure how to submit secondary claims electronically, contact your practice management system vendor or contact an EDI representative at 800-435-2715.

Coordination of Benefits
Coordination of Benefits (COB) is a provision included in both member and physician and provider contracts. When two or more health plans cover a member, COB protects against double or over-payment. When we process a claim, we coordinate benefits if the member has other primary coverage from another carrier, our health plan, service plan, or government third-party payer. We'll coordinate the benefits of the members plan with those of other plans to make certain that the total payments from all plans aren't more than the total allowable expenses.

We abide by the following COB standards to determine which insurance plan pays first (primary carrier) and which pays second (secondary carrier). Briefly, these rules are as follows:
1. A member is primary on the plan in which he/she is the subscriber versus the plan in which he/she is a dependent. When a member is the subscriber on more than one plan, when both plans have a COB provision, the plan with the earliest effective date pays first (primary).
2. When a dependent is double-covered under married parents' health plans, the primary plan is the coverage of the parent with his/her birthday earlier in the year, regardless of their actual age. This standard is called the "Birthday Rule."
3. When dependent children are double-covered by divorced parents, coverage depends on any court decrees. Generally, if the court decrees financial responsibility for the child's healthcare to one parent, that parent's health plan always pays first. If there are no court decrees, the plan of the parent with custody is primary.

Some group contracts are not subject to state regulations may have unique COB rules that could change the order of liability.

Billing Information
Primary submission: Show all insurance information on the claim, and then submit the claim to the primary plan first.
Secondary submission: When submitting secondary claims to us, submit the primary processing information with the submission of the secondary claim.

How Payments Are Made
When applicable, we will suspend payment until we determine which carrier is primary and which is secondary. We may send a questionnaire to the member regarding possible duplicate coverage. We need the member to promptly complete and return this questionnaire to process claims in a timely manner. When we are the primary carrier, we calculate and pay benefits routinely.

It is important to file a claim with all insurance companies to which the member subscribes. To ensure prompt and accurate payment when Premera is the secondary carrier, we encourage you to send the secondary claims with the primary processing information as soon as you receive it.

If we do not receive the EOB, and are unable to obtain the primary payment information by phone, the claim will be denied with a request for a copy of the primary EOB before processing can be completed. If you have questions about COB, contact Customer Service by calling the phone number on the back of the member's ID card.

Third-party Liability and Subrogation
Subrogation permits the plan to recover payments when the negligence or wrongdoing of another causes a member personal illness or injury. A subrogation provision is included in both member and physician/provider contracts. In third-party cases, this provision permits the plan to recover the medical bill costs on behalf of the member.

Injury Accident Claims
The member's benefit program contains special provisions for benefits when an injury or condition is:
- Caused by another party (e.g., slip and fall, medical malpractice, etc.)
- Covered under the provisions of motor vehicle medical policy, personal injury protection (PIP), medical payments (Medpay)
- Uninsured (UIM) and/or underinsured (UM) motorist or other similar coverage (e.g., homeowners, commercial medical premises)
- Covered by Worker's Compensation.

An onset date should be recorded on all accident-related claims. The claim(s) will suspend and a processor will review to determine whether to send an Incident Questionnaire (IQ) to the member. (The IQ is available in the Provider Library under *Forms*. You can print and assist the member in completing the form, but it's important to review the instructions included with the form because the patient must complete the form and then sign it.) If the member does not return the IQ within the specified timeframe, we will deny all related claim(s). Once the IQ is returned, all claims are reviewed and processed based on the information supplied. The member or provider can submit the completed IQ using one of the following methods:

- Fax it to: 425-918-5355 or 425-918-5878
- Mail it to: Subrogation Department
  MS 227
  P.O. Box 327
  Seattle, WA 98111-327

The member may contact Customer Service (the number is on the back of the ID card) to update IQ information over the phone. If all pertinent information is obtained, the claim(s) will then be processed according to the member's contract benefits. If we need additional information for subrogation determine to pay or deny, the IQ will either be sent back to the member requesting the information, or subrogation will make two calls within five days of receiving the IQ. If member does not return the call, claims will be denied until information is received. If member returns the call and the information is obtained, claims will be processed.

We will send the member an IQ if the claim(s) is potentially accident-related. When the member completes and returns the IQ form to Calypso Subrogation department, a representative will screen the document to determine if another party is responsible for processing claims prior to the health carrier stepping in. This review is necessary to determine whether the claim(s) should be covered by a first-party carrier (e.g., PIP, Med Pay or similar coverage – homeowners or a commercial medical premise policy).

Benefits are not available through us until the first-party carrier has exhausted, denied, or stopped paying due to its policy limits. Once we have received a payment ledger from the first-party carrier(s) showing where they paid out their limits (with dates of services, provider names, total charges, total paid, etc.), claims will be processed accordingly and under the terms of our subscriber's contract. If the IQ states that there is no first-party coverage(s) available, but there is a third-party that is responsible for the incident, we will process all related claims based on the member's contract with us until all parties are ready to negotiate a settlement for possible reimbursement.

Workers' Compensation
Workers' Compensation will pay when the member's employer is liable to pay medical bills resulting from illness or injury arising out of, or in, the scope of employment. All of our contracts exclude coverage for care covered under the Workers' Compensation Act.

Claims submitted that indicate possible Workers' Compensation illness or injuries are investigated. We send the member a questionnaire requesting information to determine if benefits are available. If we do not receive a response within the specified period, the claim(s) is denied pending further information. If the information received indicates an on-the-job illness or injury, both the member and physician/provider will receive a denial that states the Premera contract excludes work-related conditions. If Workers' Compensation denies payment of such claims, Premera will pay according to the subscriber's contract benefits after receiving a copy of a valid denial.

Provider Appeals
Physicians and providers have the right to appeal certain actions of ours. Our provider appeals process ensures that we address a complaint or an appeal in a fair and timely manner. Our process meets or exceeds the requirements set by the Office of the Insurance Commissioner.

The provider appeals process does not apply to FEP, BlueCard Home Claims, Medicare Supplement plans, or Medicare Advantage plans.

Important: You have the option to start the appeals process at the complaint or Level I Appeal stage; however, either stage must take place within 365 days of the our action that prompted the dispute.

Complaints
You can submit a complaint about one of our actions (verbally or in writing) to one of our associates. You have 365 calendar days to submit a complaint following the action that prompted the complaint. Complaints received beyond the 365 day timeframe will not be reviewed and the appeals rights pertaining to the issue will be exhausted.

If we receive the complaint before the 365-day deadline, we review and issue a decision within 30 calendar days via letter or revised Explanation of Payment. You also receive information about how to submit a Level I Appeal if you disagree with the decision.

You can make a complaint verbally to Customer Service or in writing to Customer Service Correspondence. You can reach Customer Service by calling 800-722-4714, option 2. The plan mailing addresses are in Chapter 1.

Level I Appeal
A Level I Appeal is used to either:
- Dispute one of our actions
- Appeal a decision on a previously submitted complaint

If you already filed a complaint and are appealing its outcome, the Level I Appeal must be submitted within the same 365-day time period of the action that prompted the dispute. Only appeals received within this time period will be accepted for review. Appeals rights will be exhausted if not received within the required timeframe.

Modifications we make to your contract or to our policy or procedures are not subject to the appeal process unless we made it in violation of your contract or the law.

A Level I Appeal is used for both billing and non-billing issues. A billing issue is classified as a provider appeal because the issue directly impacts your write-off or payment amount. A non-billing issue is classified as a member appeal because the financial liability is that of the member, not the provider (please refer to Chapter 6). Here are examples:

Billing Examples	Non-Billing Examples
Multiple Modifier Reimbursement	Service not a benefit of subscriber's contract
Bundling or Inclusive Procedures	Investigational or experimental procedure

A Level I Appeal must be submitted with complete supporting documentation that includes **all** of the following:
1. A detailed description of the disputed issue
2. Your position on the disputed issue
3. All evidence offered by you in support of your position including medical records
4. A description of the resolution you are requesting

Incomplete appeal submissions are returned to the sender with a letter requesting information for review. The time period does not start until we receive a complete appeal. Once the submission is complete and if the issue is billing related, we review the request and issue a decision within 30 days, along with your right to submit a Level II Appeal if you are not satisfied with the outcome. If the issue isn't billing related, we review the request and issue a decision within 60 calendar days. Only a member can request a Level II Appeal for a non-billing issue, unless the member has completed a release to allow the provider to act as their Representative.

Level II Appeal
Level II appeals must be submitted in writing within 15 calendar days of the Level I appeal decision and can only pertain to a billing issue. If the level II appeal is timely and complete, the appeal will be

reviewed. We notify you in writing if the level II appeal is not timely and your appeal rights will be exhausted. Once we accept your level II appeal, we will respond within 15 days in writing or a revised Explanation of Payment. We also provide information regarding mediation should you disagree with the decision.

Mediation
You must request mediation in writing within 30 days after receiving the level II appeals decision on a billing dispute. We notify you in writing if the request for mediation is not timely. If your request for mediation is timely, both parties must agree upon a mediator. The mediator consults with the parties, determines a process, and schedules the mediation. If we cannot resolve the matter through non-binding mediation, either one of us may institute an action in any Superior Court of competent jurisdiction. The mediator's fees are shared equally between the parties. All other related costs incurred by the parties shall be the responsibility of whoever incurred the cost.

Submitting an Appeal
To submit a <u>Level I</u>, <u>Level II</u> or <u>Mediation</u> Appeal (see above to submit a Complaint), send complete documentation to:

<div align="center">

Physician and Provider Appeals
P.O. Box 91102
Seattle, WA 98111-9202

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