12 UB-04 Billing

Description This chapter contains participation, claims and billing information for providers who bill on a UB-04 (CMS 1450) claim form. This chapter supplements information contained within previous chapters of this manual.

Contents

Section 1: Credentialing

Description

This section describes how a Practitioner/Provider becomes "Participating" in our networks, and the steps to follow **before** seeing Premera members. See *Definitions for Credentialing Purposes* section below for the description of Practitioner/Provider.

Becoming a Participating Practitioner/ Provider

Prior to becoming a member of our Practitioner/Provider network, a Practitioner/Provider must first successfully complete the credentialing process. The majority of our Practitioners/Providers complete the credentialing process within 60 days or less.

The credentialing process requires a new Practitioner/Provider to submit an application. To start the credentialing process, request an application by contacting Physician and Provider Relations at 877-342-5258, option 4. Next, the Practitioner/Provider must be credentialed by Premera and sign a PREMERAFIRST Facility Agreement to participate in our network.

Credentialing Process

The Company reviews each Practitioner/Provider with which it contracts. Prior to initial contracting the Practitioner/Provider is reviewed to verify it is:

- Licensed by the state, as applicable
- In good standing with state and federal regulatory agencies
- Medicare certified or approved, as applicable
- Accredited by a recognized accrediting body (e.g. TJC/AAHC/etc.), as applicable

If the Provider is not accredited, it must meet Company standards of participation which include:

- A Company on-site assessment; or
- State/Centers for Medicare and Medicaid Service (CMS) survey

The Practitioner/Provider has the right to review submitted credentialing application information; to be notified of any information that is substantially different from what the Practitioner/Provider submitted; the right to correct erroneous information; and the right, upon request, to be informed of the status of their application.

The credentialing department responds to these requests via phone, letter or by email. The Practitioner/Provider is notified of these rights via news brief, newsletter and/or letter.

Re-credentialing

To maintain quality standards, we re-credential established Practitioners/Providers every three years.

Credentialing Standards for Premera Plans

Credentialing standards are those criteria that all Participating Practitioners/Providers must meet and maintain to begin or continue to participate in our health plans. Practitioner/Provider credentialing decisions are made by the Credentialing Committee.

Hospital Credentialing Guidelines

Premera follows national credentialing standards regarding the staff in a hospital system who must be credentialed.

I. Practitioners/Providers who must be credentialed by Premera Blue Cross are those who:

- Have an independent relationship with Premera and provide care under our medical benefits.
- See patients **outside** of a facility's inpatient setting or outside of a freestanding ambulatory facility (e.g., PT, OT).
- Are hospital-based but also see patients in their independent relationships with Premera.
- Are dentists who provide care under Premera's medical benefits.

II. Practitioners who do not require credentialing by Premera Blue Cross are those who:

- Practice exclusively within the facility setting and who provide care for Premera patients. Examples include:
  - Anesthesiologists
  - ER physicians
  - Hospitalists
  - Neonatologists
  - Pathologists
  - Radiologists

Definitions for Credentialing Purposes

Hospital-based: A Physician or other Practitioner who practices exclusively within the hospital or facility setting. Premera determines any exceptions based on how patients receive care.

Physician: A Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Practitioner: An individual who provides professional healthcare services and is licensed, certified, or registered by the state in which the services are performed.

Provider: An organization that provides healthcare services such as hospitals, home health agencies, skilled nursing facilities, surgical centers and behavioral health facilities, and is licensed by the state in which services are performed.

Supervision: A Physician or other Practitioner acting in an oversight capacity who consistently reviews the medical care and records of a patient when services are provided by another caregiver who, in other circumstances, could practice independently of supervision by license (e.g., PT, OT) must be credentialed by Premera.

***Note*:** A therapist providing outpatient services in a hospital system is considered an independent Practitioner unless supervised as described above.

Practitioner/ Provider Credentialing Notifications

Practitioner/Provider Right to Review Credentialing File:
A Practitioner/Provider has the right to review their credentialing file by notifying the Credentialing Department and requesting an appointment to review their file. Allow up to seven days to coordinate schedules. Contact Physician and Provider Relations at 877-342-5258, option 4.

Practitioner/Provider Right to Correct Erroneous Information:
A Practitioner/Provider has the right to correct erroneous information. The Company will notify the Practitioner/Provider in writing in the event that credentialing information obtained from other sources varies from that supplied by the Practitioner/Provider. The

Practitioner/Provider must explain the discrepancy, may correct any erroneous information and may provide any proof available.

Practitioner/Provider Right to be Informed of Application Status:
Practitioners/Providers have the right upon request to be informed of the status of their credentialing application. Please note that after the initial credentialing process, Practitioners/Providers who are in the recredentialing cycle are considered approved unless otherwise notified. Contact Physician and Provider Relations at 877-342-5258, option 4.

Section 2: Contracting

Contracting Process

Contracting for specific lines of business discussed in this manual occurs **after** our credentialing process is complete. Once contracts are signed by the provider and counter-signed by Premera, the newly credentialed and contracted provider can then render medical services to our members and submit claims for payment.

Our Health Care Delivery Systems department is responsible for contracting. For contracting questions contact Physician and Provider Relations at 877-342-5258, option 4, to be connected with your assigned Provider Network Executive (PNE) or Provider Network Associate (PNA).

Terminating a Contract

State and federal regulations require that we ensure that members are appropriately transitioned whenever a provider contract is terminated.

To ensure continuity of care, the member must be notified and given the opportunity to transfer care to another contracted provider **prior to the termination date**. This process applies to all plans and whenever a provider terminates their Premera contract.

Termination Notice

Providers are contractually required to provide Premera with a termination notice as set forth in their contract.

Section 3: Hospital Inpatient Notification

Description

Admission Notification

Hospitals routinely notify Premera of all inpatient admissions, which allows us to verify benefits, link members to other programs and assess the need for case management. Some plans may be subject to prior authorization, please refer to back of member ID card.

Services requiring admission notification:

- Inpatient admissions – Nonemergency, elective or scheduled admissions (including mental health and chemical dependency)
- Skilled nursing facility and acute rehabilitation admissions
- Acute care hospitals
- Inpatient hospice
- Mental health and chemical dependency residential treatment centers

Admission Notification policies and procedures:

- Premera should be notified of urgent/emergent admissions within 48 hours of the admission.
- Maternity admissions related to delivery do not require admission notification for the first 48 hours for vaginal delivery or the first 96 hours for C-section. Inpatient stays beyond the first 48 hours for vaginal delivery or the first 96 hours for C-section require admission notification.
- The admission notification process should be completed prior to admission for other scheduled, elective procedures.
- If the procedure or condition is subject to medical necessity review, a request for a benefit advisory/prior authorization review should be submitted before the member is admitted to the hospital.

Notification Process

Submit Admission Notification:

- **By fax**: The Admission Notification form is located on the provider portal in two locations.
  1. Forms section under Care Management
  2. Admission Notification tool (OHP login required)

  Note: You may also fax in the hospital census to 800-866-4198.
- **By phone**: 877-342-5258, option 3

Please have the following information available when you report a medical, mental health or chemical dependency inpatient or residential treatment admission:

- ✓ Facility name
- ✓ Facility phone number
- ✓ Member name and/or identification number
- ✓ Health plan product
- ✓ Actual date of admission
- ✓ Attending physician or other provider
- ✓ Admitting diagnosis (English or ICD-9 code)
- ✓ If available, admitting procedure code (English or ICD-9/CPT code)

Interactive Voice Response	**Interactive Voice Response (IVR)**: Self-service option and is available 24 hours a day, seven days a week. Callers enter the member's ID number, date of birth, and the physician or other provider's tax ID number to obtain eligibility, general benefit information, and claims information.
	Note: To report an inpatient admission you may call the Care Management IVR at 877-342-5258 option 3, Monday through Friday, 8 a.m. to 5 p.m. Pacific Standard Time or you may fax to 800-866-4198.
Medical Necessity Criteria	We use Milliman criteria, American Society of Addiction Medicine criteria (ASAM) and plan medical policy to determine the medical necessity of each member admission and length of stay for all medical, mental health and chemical dependency facility-based treatments.

Section 4: Transfer of Patients to/from Facilities

Description

A discharge planner notifies Care Management about the possibility of a patient facility transfer. When this occurs, Care Management helps facilitate a transfer to a contracted facility whenever medically appropriate.

Prior to all non-emergent transfers, please confirm with Customer Service that the facility is contracted for the health plan and contracted for the proposed services. Some facilities have contracts limited to special or limited services and are not contracted for all services they provide.

Transfer to a Non-Contracted Facility

Some member contracts will allow the use of a non-contracted facility at a lower benefit level. For non-emergent transfers contact Customer Service to determine if the member contract allows for the lower level of reimbursement. Medically necessary services that cannot be reasonably provided at a contracted facility within the product-specific network will be prospectively assessed for possible authorization of non-contracted provider use at the maximum benefit level.

Transfer from a Non-Contracted Facility

In an emergency, members may be hospitalized at non-contracted facilities. Premera will assess each member's situation for appropriateness of a transfer to a contracted facility. Transfer decisions are made based on Premera policy for medical stability, attending physician or other provider agreements, member and/or family agreement to transfer, and expected duration of stay.

To contact Care Management, please call 877-342-5258, option 3.

Section 5: Hospital Bill Audits

Hospital Bill Audits

Calypso* administers the hospital bill audit process on behalf of Premera Blue Cross.

The purpose of the audit is to:

1. Compare the provider's billed charges to documentation in the medical records and ensure that services to our members are ordered, documented, administered, coded, and billed correctly.
2. Compare the provider's coding on a claim against the provider's contract.
3. Compare the provider's billed charges to the Premera Blue Cross contract exclusion list for inpatient services.

Audit Conclusion

When the audit is complete, the auditor will meet with a hospital auditor to review the findings. This could result in refunds and/or the reprocessing of claims to pay additional benefits.

*Calypso provides investigation and recovery services for Premera Blue Cross and its subsidiaries and affiliates. For questions specific to Calypso processes, please call 800-364-2991.

Section 6: UB-04 (CMS 1450) Guidelines

Description

The remaining sections provide information about how to bill Premera to obtain payment for eligible healthcare services rendered to our members.

UB-04 (CMS 1450) Billing Guidelines

The Centers for Medicare and Medicaid Services (CMS) form 1450, referred to as the UB-04, is the standard claim form used to bill facility services to Premera and its affiliates.

Submitting the claim form with all required fields will assist us in paying your claim in a timely manner. Claim forms that are missing one or more of the required fields may be rejected or denied.

It is necessary to follow the guidelines provided in the National Uniform Billing Manual when completing this form for all facility services rendered to a member. It is also necessary to follow the established definitions and guidelines for each type of diagnosis or procedure code used (i.e., CPT, ICD-9, and HCPCS). When completing the form be sure to include information regarding other insurance coverage, the facility tax identification number, itemized dates of service, procedure codes, and revenue codes to assist in proper and timely payment of all claims.

For additional information you can reference:

- The National Uniform Billing Manual at nubc.org.
- The Medicare Hospital Manual at cms.hhs.gov in the *Regulations* and *Guidance & Standards - Manuals* section (reference *Paper-Based Manuals*).
- Diagnosis and procedure code guidelines at cms.hhs.gov/home/medicare.asp in the *Coding* section.

Careful attention to the following items on the UB-04 will also assist us in processing your claim accurately and promptly:

- **Type of Bill** (form locater 4): The third digit of the type of bill indicates whether the bill is a final, interim, corrected, or supplemental claim. This affects the benefit payment so be sure to use the appropriate code to avoid incorrect payment and subsequent reprocessing of a claim.
- **Patient Status** (form locater 17): The patient status code is a required item and must be available to identify transfer situations.
- **Occurrence Codes** (form locaters 31 – 36): Occurrence codes and dates should be completed for all accident, maternity, and illness claims.
- **Room Rate** (form locater 39): Indicate the semi-private room rate. Facilities that do not have a semi-private room rate for the service should include the private room rate dollar value in this field.
- **Service Date** (form locater 45):
    - **Outpatient Claims:** This is a mandatory field and must be populated.
    - **Inpatient Claims:** Room and board lines must be itemized - one line for each date of service.
- **Maternity Claims**: All mother/baby bills should be submitted as two separate claims, batched together for either paper or electronic submission.
- **SNF Claims**: When billing for secondary coverage, document the level of care in the remarks field (form locater 80).

Reimbursement Reimbursement is subject to the terms defined in the contract between the facility and Premera. Final payment is subject to Premera's fee schedule and payment policies, a member's eligibility, coverage and benefit limits at the time of service, and claims adjudication edits common to the industry and/or adopted as Premera Payment Policy.

Section 7: Interim Bills and Late Charges

Interim Bills

Please submit interim bills for lengths-of-stay in excess of 30 days with the following criteria. Interim bills submitted with lengths-of-stay less than 30 days will be returned to the facility.

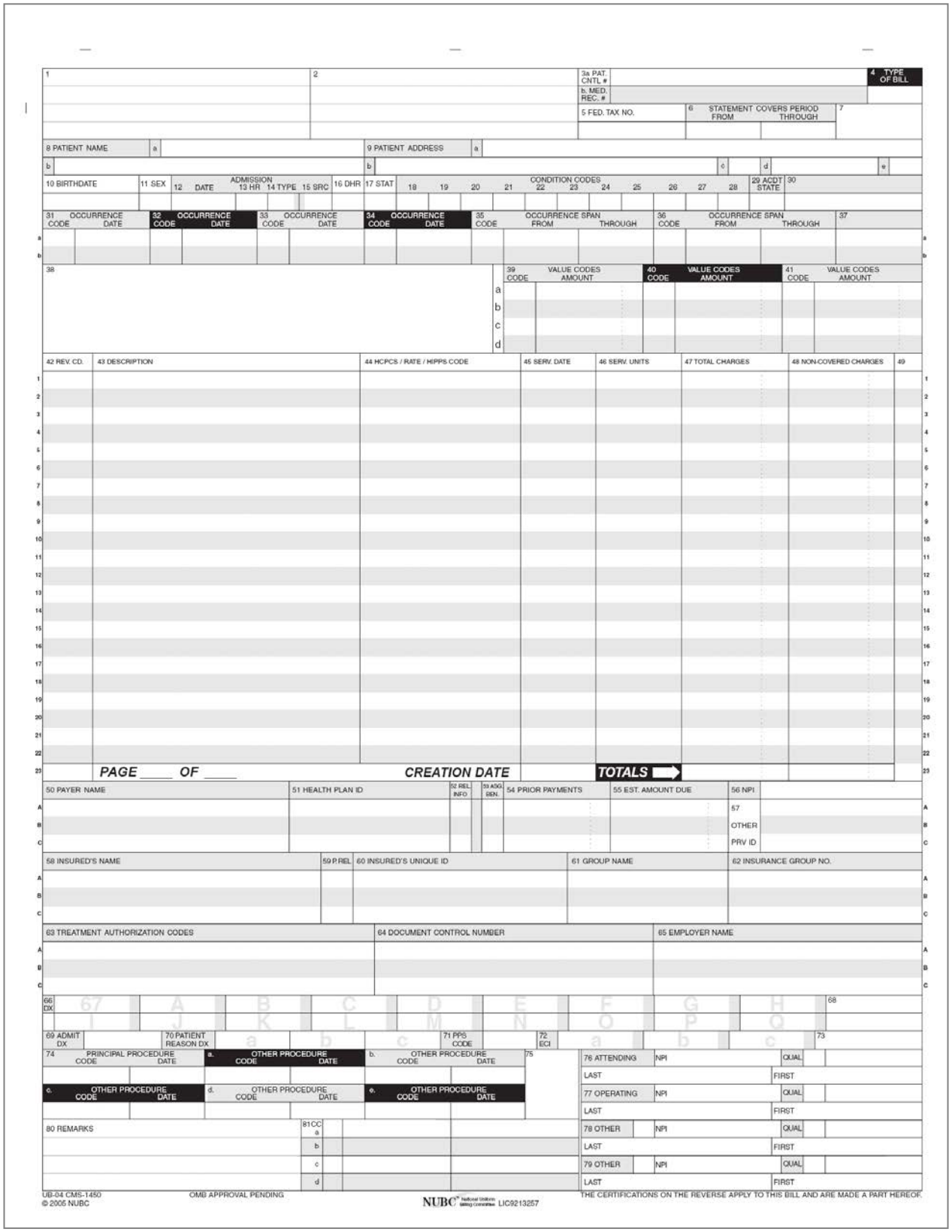
- Initial claim: Bill type 112
- Subsequent claim(s): Bill type 113
  - The admission date should be the same on all related claims. The beginning and ending dates must reflect the dates of service being billed for each subsequent claim.
  - The interim claims must be billed in date sequential order.
- Final claim: Bill type 114 or 117
  - The final claim must include all diagnosis and ICD-9 procedure codes related to the entire stay. The beginning and ending dates must reflect the admission and discharge date (entire stay).

Each interim claim will be processed based on the computed DRG, APDRG or MS-DRG. The final bill (bill type 114 or 117) will determine whether additional reimbursement or an adjustment will be made.

Late Charges

Supplemental claims should be submitted when an additional charge is realized after the final claim has been submitted. If you are submitting a late charge, indicate the additional charges and the beginning and ending dates of service. Late charges are added to the original claim and processed according to contractual agreements.

Section 8: Sample UB-04 (CMS 1450) Claim Form



Section 9: Ambulatory Surgery Centers (ASCs)

Description

An Ambulatory Surgery Center (ASC) is a freestanding facility, other than a physician or other provider's office, where surgical and diagnostic services are provided on an ambulatory basis.

Ambulatory Payment Classification Methodology

Most ASCs contracted with Premera utilize a payment methodology modeled after the CMS Ambulatory Payment Classification (APC) methodology for ASCs, with services billed on a CMS-1500 claim form. ASCs whose payment is based on the Medicare APC methodology are paid a 'facility fee' modeled after CMS. Premera supplements the list with additional procedures.

Note: The physician or other provider who performs the surgery in an ASC is also paid for his or her professional services. A claim is filed for the physician or other provider services, separate from the ASC facility services.

Note: Reference the facility agreement to confirm your specific billing and reimbursement methodology, and reimbursement rates.