**Reporting the ICD Qualifier/Indicator on Paper Claims**

Effective Oct. 1, 2015, covered entities covered under the Health Insurance Portability and Accountability Act (HIPAA) are required to report the ICD Qualifier/Indicator on all paper claim submissions.

Here are the important points to follow when making system changes to implement ICD-10 on paper claims:

- The ICD Qualifier/Indicator must be reported in Form Locator 66 of the UB-04 or Box 21 of the NUCC 1500 claim form.
- Your system may currently submit this qualifier using a default of “9” as ICD-9 is the only acceptable code set version at this time. It’s important that this default is removed on Oct. 1, 2015, to properly report ICD-9 or ICD-10.
- The ICD Qualifier of “9” should be reported for ICD-9 coded claims or “0” for ICD-10 coded claims.
- The ICD Qualifier/Indicator must match the code set version being reported.
- The Centers for Medicare and Medicaid Services (CMS) Billing Guidelines for ICD-10 are available on our Provider website at bcnepa.com/Privacy/ICD-10.aspx. We will be following these guidelines with one exception: Guidelines that state a claim will be “returned as unprocessable,” will not apply to Blue Cross of Northeastern Pennsylvania claims. Instead, the claim will be rejected.

(For more information, visit the CMS resources listed on our ICD-10 webpage.)

**Preparing for ICD-10: Understanding GEMs**

In order to prepare for ICD-10 implementation on Oct. 1, 2015, the Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) created General Equivalence Mappings (GEMs). The GEMs are tools for the conversion of data from ICD-9 to ICD-10 codes and are designed as a general purpose translation tool for anyone who wants to convert coded data.

It is important to understand, however, that the GEMs are more complex than a simple one-to-one “crosswalk.” In fact, according to ICDLogic, only about 12 percent of the GEMs mappings from ICD-9 to ICD-10 procedure codes offer a one-to-one match. This means that someone using GEMs could crosswalk to one or more of several hundred possible codes. In such cases, human intervention and judgment, based on the proper analysis of accurate, complete and specific clinical documentation, are required to complete the links.

When assessing your ICD-10 readiness, remember that achieving clinically correct coding should not depend on GEMs. Instead, it requires analysis of the clinical documentation for each patient. While the GEMs are valuable reference mappings that can help the user navigate the complexity of meaning from one code set to the other, they are not intended to be a substitute for learning to use and apply the ICD-10 coding system.

For more information, visit the CMS resources listed on our ICD-10 webpage.

**Sources:**
- American Health Information Management Association (AHIMA): “Putting the ICD-10-CM/PCS GEMs into Practice.”
- ICDLogic: “Use Caution When Entering the Crosswalk. A Warning About Relying on GEMs as Your ICD-10 Solution.”

(For more information, visit the CMS resources listed on our ICD-10 webpage.)
Reconsideration Requests for Retrospective Reviews

As noted in previous editions of the Provider Bulletin, to initiate the reconsideration process for a prior approval request, providers must contact Utilization Management within five business days from the receipt of the denial notification. Beginning Aug. 1, 2015, this process will also apply to retrospective review requests.

Our medical directors are available to discuss denial decisions any time after a denial, but the request will be processed as a reconsideration review only when it is made within five business days of the denial notification. A formal appeal process will need to be completed for any request received after the allowed timeframe.

Reminders:

Submitting Prior Approval Requests for Skilled Nursing, Long-Term Acute Care and Rehabilitation Facilities

As you know, all NaviNet®-enabled providers are required to use NaviNet for prior approval submissions and inquiries.

To further improve the efficiency of our processes, starting Sept. 1, 2015, we will require that all skilled nursing facilities, rehabilitation facilities and long-term acute care facilities submit requests for clinical review to Utilization Management via NaviNet only. If you are unable to submit requests via NaviNet, you must call Utilization Management to submit your request. Our current fax worksheets will be discontinued after Sept. 1.

If you submit a request by phone, please have all applicable clinical information prepared before calling to ensure the review can be completed in a timely manner.

Please note: Priority is given to all requests that are submitted through the NaviNet system. Requests submitted by phone will be reviewed only after NaviNet requests have been completed.

Attention Acute Care Providers: NaviNet Functionality Update

Reminder: All First Priority Life Insurance Company® (FPLIC) requests for inpatient admissions (except routine maternity) now require prior approval.

Our NaviNet functionality has not yet been updated to accommodate this change. You may continue to submit your prior approval requests through NaviNet; however, you may receive a message that states prior approval is not required for an inpatient admission. If you receive this message, please submit your request by calling Utilization Management.

Providers who are measured on their NaviNet utilization should indicate on the request that they were unable to submit through NaviNet.

Prior Authorizations and Transitioning to ICD-10

For the implementation of the ICD-10 coding system on Oct. 1, 2015, Blue Cross of Northeastern Pennsylvania’s transition for coding on prior authorization requests will be based on the date the authorization was submitted:

• If an authorization is submitted on or after Oct. 1, 2015, ICD-10 codes must be used.
• If an authorization is submitted on or before Sept. 30, 2015, ICD-9 codes must be used.
• Authorizations that were already submitted with ICD-9 codes for services spanning the Oct. 1, 2015, transition date do not need to be updated.
• We can process an ICD-10 coded claim against ICD-9 coded authorizations. ICD codes are not used to match an authorization to a claim.
Important Information:
Discharge Notification Process
Effective Aug. 1, 2015, prior approvals for inpatient care will only be valid up to the last date that clinical information is received from the provider.

In order to extend this authorization period, the provider must submit additional clinical information or a discharge notification within 10 calendar days. Utilization Management will not be contacting providers for this information.

If an update is not received, the member’s discharge date will be documented as the last day of the authorization period.

Please note: If the proper discharge date is not documented and there is a discrepancy during the claims adjudication process, the claim may reject, delaying payment.

Submitting Prior Approval Requests
When submitting a request for a prior approval review, please include all pertinent clinical information with the request. Prior approval reviews will be processed using the clinical documentation that was submitted at the time of the request.

In addition to clinical documentation, all requests must include the following information:

- Member’s name
- Member’s identification number
- Date(s) of service
- Facility where services are to be rendered
- Diagnosis/procedure code(s), as applicable

Filing Claims for Air Ambulance Services
Reminder: Claims from providers of emergency and non-emergency air ambulance services are to be filed with the local Plan, in whose service area the point-of-pickup ZIP code is located. This change became effective April 9, 2015.

How to file using point-of-pickup ZIP codes:

CMS 1500 Claim Form
- Populate item 23 with the 5-digit ZIP code of the point of pickup.
- For electronic claims, populate the origin information (ZIP code of the point of pickup) in the Ambulance Pickup Location Loop in the ASC X12N Health Care Claim (837) Professional.

CMS 1450 (UB-04)—This is used for air ambulance service not included with local hospital charges.
- Populate Form Locators 39-41, Code A0 (Special ZIP code reporting), with the 5-digit ZIP code of the location from which the beneficiary is initially placed on board the ambulance.
- For electronic claims, populate the origin information (ZIP code of the point of pickup) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.

Important:
- Air ambulance claims filing rules apply regardless of the provider’s contracting status with the Blue Plan where the claim is filed.
- Whenever possible, providers are encouraged to verify member eligibility and benefits, by calling 1-800-676-BLUE (2583). This number is also located on the back of member ID cards.
- Providers are also encouraged to utilize in-network participating air ambulance providers to reduce the possibility of additional member liability for covered benefits.
- Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider’s responsibility to request payment directly from the member for non-covered services.

(Policy Update 1708003)
Handling Claims for Medicaid Members

Identifying Medicaid Members to Determine Eligibility & Benefits

BCBS Plan ID cards do not always indicate that a member has a Medicaid product. BCBS Plan ID cards for Medicaid members do not include the suitcase logo that you may have seen on most BCBS ID cards, but they do include a disclaimer on the back of the ID card providing information on benefit limitations. For members with such ID cards, you should obtain eligibility and benefit information and prior authorization for services using the same tools as you would for other BCBS members:

• Submit an eligibility inquiry by calling the BlueCard® Eligibility Line at 1-800-676-BLUE (2583).
• Submit an eligibility inquiry using BlueExchange®.

Medicaid Reimbursement & Billing

Claims for all BCBS Medicaid members should be submitted to your local BCBS Plan. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member’s home state. Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (42 CFR 447.15).

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have applicable copays, deductibles or coinsurance applied to the member’s plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

New HEDIS Measures Now Available Online

The following HEDIS measures will be added to the HEDIS Homepage in August:

Use of Appropriate Medications for People with Asthma (ASM)

Measure Description:

The percentage of members, 5 to 64 years of age during the measurement year, who were identified as having persistent asthma, and were appropriately prescribed medication during the measurement year.

Medication Management for People with Asthma (MMA)

Measure Description:

The percentage of members, 5 to 64 years of age during the measurement year, who were identified as having persistent asthma, and who were dispensed the appropriate medications, which they remained on during the treatment period.

Two rates are reported:

• The percentage of members who remained on an asthma controller medication for at least 50 percent of their treatment period
• The percentage of members who remained on an asthma controller medication for at least 75 percent of their treatment period

Visit the HEDIS Homepage at bcnepa.com/providers/qualitymanagement for these and other measures with documentation tips, best practices and information about the importance of these measures to your practice.
**Medicaid Billing Data Requirements**

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims. These data elements, and other data elements that are important to submit (when applicable) on Medicaid claims, are included below.

**Effective March 2016, applicable Medicaid claims submitted without these data elements will be denied. Prior to March 2016, applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:**

- National Drug Code
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT)
- Service Facility Name and Location Information
- Ambulance Transport Information
- Patient Weight
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

**Medicaid Encounter Data Reporting**

The data elements mentioned above need to be included on Medicaid claims, so that BCBS MCOs are able to comply with encounter data reporting requirements applicable in their respective state.

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**Reminder: Outpatient Laboratory Program Survey**

We ask all First Priority Health® primary care physicians and specialists in Luzerne and Lackawanna Counties to please complete the Outpatient Laboratory Program Survey that will be mailed to you in early August and return it in the envelope you received by Aug. 28, 2015. Your comments about the services you have been receiving through our outpatient laboratory program are very valuable.

(Policy Update 1708006)
Provider Enrollment Requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive information from your local BCBS Plan regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you may receive reimbursement.

Commonly Asked Questions

How do I submit Medicaid claims?
Medicaid claims should be submitted to your local BCBS Plan in the same manner as you submit claims for other BCBS members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

How do I know that I am seeing a Medicaid member?
Members enrolled in a BCBS Medicaid product are issued BCBS Plan ID cards. BCBS Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. BCBS Plan ID cards for Medicaid members:
• Will not include a suitcase logo
• Will contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness

Providers should always submit an eligibility inquiry if the Plan ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard: BlueCard Eligibility Line and BlueExchange.

Because Plan member ID cards will not always indicate that the member is enrolled in a Medicaid product, you should always obtain eligibility and benefit information. With an eligibility response, you should receive information on Medicaid coverage.

What amount should I expect to receive for members that reside outside of the Highmark Blue Cross Blue Shield service area?
When billing for services rendered to an out-of-state Medicaid member, you will be reimbursed according to the member’s home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

My state does not require me to include an NPI or NDC code and many of the other data elements listed above on a Medicaid claim. Why do I have to include these codes?
Most state Medicaid programs require NPI and NDC codes and the additional data elements (when applicable) to be populated on claims submitted for Medicaid members for encounter data reporting purposes. To ensure compliance with state Medicaid requirements, providers who bill for Medicaid members should include these data elements on applicable BCBS Medicaid claims or the claims may be pended or denied.

I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?
Many state Medicaid programs require providers to enroll before reimbursement may be provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

Who should I contact if I have questions?
Please call your Provider Relations consultant if you have any questions about this information.

Source: Blue Cross Blue Shield Association

(63x499)
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Source: Blue Cross Blue Shield Association

(63x499)
**Electronic Claims Submission**

As you know, Blue Cross of Northeastern Pennsylvania (BCNEPA) is now Highmark Blue Cross Blue Shield. Highmark places a high priority on electronic claims filing and the electronic exchange of information, which is more efficient and cost effective than conventional means and beneficial to health care professionals, members and insurers.

**EDI Submissions**

We want to remind you that as current BCNEPA members renew their individual and group contracts for 2016 health care coverage they will be transitioning to Highmark health plans and receiving new Highmark-branded ID cards. Claims and inquiries for these former BCNEPA members should be submitted using the Central Region/Highmark Blue Shield Provider Resource Center:

- Go to [www.highmarkblueshield.com](http://www.highmarkblueshield.com).
- Click on **Provider Resource Center**.
- Select **Electronic Data Interchange (EDI) Services**.

Please note that some of your patients may be staying in BCNEPA health plans through 2016 (and, with claims runoff, possibly into 2017). Therefore, you should continue to submit claims for these members via BCNEPA’s EDI.

**To summarize:**

- BCNEPA members who have transitioned to Highmark will have a Highmark ID card.
- BCNEPA members who have not yet transitioned will continue to have a BCNEPA ID card.

**Misrouted/Rejected Claims**

If you do submit a claim to the wrong entity, the claim rejection will read one of the following:

- A8/33 - Subscriber and subscriber ID not found
- A8/116 - Claim submitted to incorrect payer

You should then use NaviNet® to confirm the member’s correct coverage entity (BCNEPA, Highmark or another carrier) and resubmit the claim, as appropriate.

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**Electronic Remittance Advice (ERA)**

Effective Sept. 1, 2015, the ERA form will be removed from BCNEPA’s provider website. All new Highmark electronic remittance advice (835) requests for 2016 coverage need to be submitted using the Central Region/Highmark Blue Shield Provider Resource Center:

- Go to [www.highmarkblueshield.com](http://www.highmarkblueshield.com).
- Click on **Provider Resource Center**.
- Select **Electronic Data Interchange (EDI) Services**.

Requests for changes for existing BCNEPA ERA providers or for cancellation of an ERA for an existing BCNEPA provider need to be emailed to ProviderERA@bcnepa.com.

- For a change request (routing to a different clearinghouse), indicate “Change Request” in the email’s subject line.
- For a cancel request (elimination of the generation of the ERA), indicate “Cancel Request” in the email’s subject line. Once a cancel request has been received and processed, the ERA cannot be reestablished on the BCNEPA side.

The following information MUST be included in the body of the email. If any of these elements are not included, the request will be denied back to the provider:

- Entity or provider name
- Tax ID number (group, facility or solo practitioner)
- NPI (group, facility or solo practitioner)
- Line of business (First Priority Health®, First Priority Life Insurance Company® or both)
- Current routing location: clearinghouse name, Guthrie or NaviNet
- New routing location (required for changes ONLY): NaviNet, Emdeon, Relay Health, SSI, PNC, HDX, Practice Insight, Guthrie or PCC

Providers who are not currently using Highmark’s EDI site can find information and instructions on the Central Region/Highmark Blue Shield Provider Resource Center:

- Go to [www.highmarkblueshield.com](http://www.highmarkblueshield.com).
- Click on **Provider Resource Center**.
- Select **Electronic Data Interchange (EDI) Services**.

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Please share this information with any billing vendors and/or clearinghouses that you use to ensure they are aware and will be prepared for the transition to Highmark’s EDI.

Our goal is to ensure a smooth transition for you and your patients. In the next few months, you will be receiving more information. In the interim, if you have any questions, please call Highmark EDI at 1-800-992-0246, or contact your Provider Relations consultant.
Provider Bulletin is published monthly for participating physicians.

Lily A. Stahley, Editor

The information in this newsletter is for providers of plans offered through Blue Cross of Northeastern Pennsylvania, First Priority Life Insurance Company®, and First Priority Health®, which are all licensed affiliates of Highmark Blue Cross Blue Shield.

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Questions?
Call Provider Relations at
1-800-451-4447

Prepare for ICD-10 with “What’s Up Wednesday”

An ICD-10 preparedness teleconference series from Pennsylvania’s Blues Plans:
Blue Cross of Northeastern Pennsylvania, Capital BlueCross, Highmark Blue Shield and Independence Blue Cross

“What’s Up Wednesday” is a monthly teleconference for Pennsylvania’s health care professionals about the transition to ICD-10. “What’s Up Wednesday” features special guests and ICD-10 experts who will lead discussions to help you get ready for the Oct. 1, 2015, compliance date.

Who should participate?
All providers, clearinghouses, trade associations and information networks.

How do I participate?
Before the call, visit Blue Cross of Northeastern Pennsylvania’s ICD-10 page at bcnepa.com. On the Provider Homepage, select the Resources and Tools tab, and then choose the Privacy/HIPAA/ICD-10 link. Click on ICD-10 to access the presentation. Dial 1-800-882-3610 and enter passcode 5411307 when prompted. Be sure to dial in a few minutes early.

Questions can be emailed before or during the teleconference to ICD10Inquiries@bcnepa.com.

(Plcy Update 1708009)