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Rendering services

Be sure to verify Member eligibility and cost-sharing amounts (i.e., Copayments, Coinsurance, and Deductibles) each time a Member is seen.

How to verify Member eligibility

Member ID cards carry important information such as name, ID number, prefix, and coverage type. If you use a Member's ID card to verify information, please keep in mind that the information displayed on the card may vary based on the Member's plan. Eligibility is not a guarantee of payment. In some instances, the Member's coverage may have been terminated.

- Always check the Member's ID card before providing service. If a Member is unable to produce his or her ID card, ask the Member for a copy of his or her Enrollment/Change Form or temporary insurance information. Members can access this information by logging onto our secure Member website via *www.ibx.com*. This form is issued to Members as temporary identification until the actual ID card is received and may be accepted as proof of coverage. The temporary ID card is valid for a maximum of ten calendar days from the print date.
- Participating facilities are *required* to use the Practice Management (PM) application on the Provider Engagement, Analytics & Reporting (PEAR) portal for all Member eligibility inquiries. There are occasions when a Member's health insurance may be effective before his or her ID card is received in the mail. In this situation, you can still verify the Member's eligibility by using the Eligibility & Benefits transaction on PEAR PM.

  If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com.*

If we are unable to verify eligibility, we will not be responsible for payment of any Emergency or nonemergency services.

Notice of Medicare Advantage HMO non-coverage

All skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must provide advance notice of Medicare coverage termination to Medicare Advantage HMO and PPO enrollees no later than two days before coverage of their services will end. However, if services are expected to be less than two days, the Notice of Medicare Non-Coverage (NOMNC) should be delivered upon admission. If there is a span of longer than two days between services, the NOMNC should be issued on the next to last time services are provided.

In addition to providing the date when coverage of services will end, the NOMNC also describes the patient's options if he or she wants to appeal the decision or would like more information.

Visit the Centers for Medicare & Medicaid Services (CMS) website at *www.cms.hhs.gov* for more information on this process.

Copayments

Members are responsible for making all applicable Copayments. The Copayment amounts vary according to the Member's type of coverage and benefits plan. In addition, please note the following:

- **Copayment verification.** Copayments can be found by selecting the various links in the Benefits & Coverages tab on the Details page when using the Eligibility & Benefits transaction on PEAR PM.

- **Collecting Copayments:**
  - Copayments may not be waived and should be collected at the time services are rendered. If a Member is unable to pay the Copayment at the time services are rendered and has been provided with prior notice of this requirement, Providers may bill the Member for the Copayment. Providers may also bill the Member a nominal administration fee for billing costs in addition to the Copayment; however, such billing fees must reflect the actual cost of the billing and must not be unreasonable or in excess of the Copayment amount.
  - *Keystone HMO Proactive Members.* For Members with coverage through Keystone HMO Proactive, our tiered Provider network plan, continue to use the Eligibility & Benefits transaction on PEAR PM to verify your patients' Copayment amount for their office visit. This transaction will display the appropriate cost-sharing amounts for all three benefit tiers. Therefore, you will need to know your benefit tier placement to determine the appropriate amount to collect from the Keystone HMO Proactive Member.
  - *Vital Care and Vital Care Plus Program Members.* For Keystone 65 Basic HMO, Keystone 65 Focus HMO-POS, Keystone 65 Select HMO, and Keystone 65 Preferred HMO Members enrolled in the Vital Care Program, a program for members with both diabetes and congestive heart failure, the specialist Copayment will vary. Therefore, the Eligibility & Benefits transaction on PEAR PM should be used to verify your patients' Copayment amount for their office visit.
  - *PPO tiered networks.* For Members in a PPO tiered network plan, acute care facilities and ambulatory surgical centers (ASC) are grouped into one of two in-network tiers, based on cost and quality measures. With these options, Members pay lower out-of-pocket costs when they receive care from tier 1 Providers.
  - *Urgent care services.* Urgent care services are available for urgent medical issues that do not require the advanced medical services of the emergency room/department (ER) when a Member's Physician is unavailable. Generally, urgent care is categorized as Medically Necessary treatment for a sudden illness or accidental injury that requires prompt medical attention but is not life-threatening and is not an Emergency medical condition when a Member's primary Physician is unavailable. Urgent care services are available at approved urgent care centers and retail health clinics.

    Copayment information for urgent care services is available on PEAR PM. Only Providers who are specifically credentialed and contracted with Independence as an urgent care Provider can charge an urgent care Copayment for urgent care services. If you have questions related to the urgent care benefit, contact Customer Service at 1-800-ASK-BLUE.
  - *Copayments relative to allowed amount for Managed Care products.* When the Copayment is greater than the allowable amount, only the allowable amount should be collected from the Member. However, a Member's cost-share is applied per visit, not per claim line. Accordingly, in a case where the Member's specified cost-sharing is greater than the allowable amount for a service during a visit, but multiple services are rendered during that visit that have an allowable amount that, in the aggregate, is greater than the Member's specified cost-sharing, the Member cost-sharing should still be collected in full. In the event that the Copayment is collected, and the facility subsequently determines that the allowed amount is less than the Copayment, the difference between the allowable amount and the Copayment for the service must be refunded to the Member.

- *Site-of-service benefits.* Large (51+) commercial fully insured and self-funded groups are offered a site-of-service benefit differential that helps Members save on out-of-pocket costs – based on where they receive care – for the following services:
  - preventive colonoscopy
  - outpatient lab*
  - outpatient surgery
  - physical/occupational therapy*
  - routine/complex radiology*

  Note: The Eligibility & Benefits transaction on PEAR PM includes a "Site of Service" indicator. This indicator is to alert Providers that the Member has a plan with a site-of-service benefit.

  **Available under PPO options only.*

- *Medicare-eligible Members.* Independence coordinates benefits for commercial Members who are Medicare-eligible, have not enrolled in Medicare Parts A or B, and for whom Medicare would be the primary payer. If a Member is eligible to enroll in Medicare Parts A or B but has not done so, Independence will pay as the secondary payer for services covered under an Independence commercial group Benefits Program (e.g., Personal Choice®, Keystone Health Plan East), even if the Member does not enroll for, pay applicable premiums for, maintain, claim, or receive Medicare Part A or B benefits. This affects any Member who is Medicare-eligible and for whom Medicare would be the primary payer.

  It is important that you routinely ask your Medicare-eligible Members to show their Medicare ID cards. If you have identified a Member who is eligible to enroll in Medicare Parts A and B, but has not done so, you may collect the amount under "Subr Liability" on the Provider Remittance, which includes any cost-sharing plus the amount Medicare would have paid as the primary payer.

- *Qualified Medicare Beneficiaries.* For Members enrolled in a Qualified Medicare Beneficiary program, Federal law prohibits Medicare Providers from collecting Medicare Part A and Medicare Part B cost-sharing for these Members. Therefore, when billing Independence for services rendered for these Members, you must accept our reimbursement, according to your Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement) with Independence, as payment in full. For enrollees who are eligible for both Medicare and Medicaid, you may bill the State for applicable Medicare cost-sharing.

– *Preventive drugs covered at $0 Copayment.* Certain preventive medications, as described in the Patient Protection and Affordable Care Act of 2010 (Health Care Reform), including generic products and those brand products that do not have a generic equivalent, are covered without cost-sharing with a doctor's prescription when provided by a participating retail or mail-order pharmacy. Drugs that are considered preventive for certain ages and genders are covered at $0 Copayment as listed in the table below.

Drug class	Gender	Ages
Folic acid (prescriptions with 0.4 – 0.8 mg)	Women only	All ages
Iron supplements	All	Children ages 6 months through 1 year
Oral fluoride	All	Children ages 6 months through 1 year
Aspirin to prevent cardiovascular disease	Men Women	45 – 79 55 – 79
Breast cancer chemotherapy prevention	Women	All ages
Tobacco interventions	All	Adults who use tobacco products
Vitamin D supplements	All	65 and older

Contraceptives, mandated by the Women's Prevention Services provision of Health Care Reform, are covered at 100 percent when provided by a Participating Provider for generic products and for those brand products that do not have a generic alternative or generic equivalent. Brand contraceptive products with a generic equivalent are covered at the brand cost-sharing level for the Member's plan.

Note: The $0 Copayment does not apply to Children's Health Insurance Program (CHIP) or Medicare Advantage HMO and PPO Members.

- **Out-of-pocket maximums:**

  – *Commercial HMO, POS, and PPO Members.* As required by Health Care Reform, Members should not be charged any cost-sharing (i.e., Copayments, Coinsurance, and Deductibles) for essential health benefits once their annual limit has been met. These limits are based on the Member's benefit plan but may not exceed $7,900.00 for an individual, and $15,800.00 for a family. To verify if Members have reached their out-of-pocket maximum, Providers should use the Eligibility & Benefits transaction on PEAR PM.

  Note: Health Care Reform regulations require an "embedded" in-network out-of-pocket maximum for each individual to limit the amount of out-of-pocket expenses that any one person will incur. This means that each Member enrolled in an individual plan, or any person in a family plan, will only pay the in-network out-of-pocket maximum set for an individual and not be required to pay out of pocket to meet the family in-network out-of-pocket maximum for the plan. For a family plan, after one person meets the individual in-network out-of-pocket maximum for their plan, the other family members continue to pay out of pocket until the remaining in-network out-of-pocket maximum amount is met.

- *Medicare Advantage HMO and PPO Members.* CMS has mandated a maximum out-of-pocket (MOOP) limit for all Medicare enrollees. The MOOP will establish an annual limit on total enrollee cost-sharing liability (e.g., Deductibles, Copayments, Coinsurance) for Medicare Part A and B services. Its dollar amount will be established annually by CMS but will not change during the course of the calendar year.

  Once Medicare Advantage HMO and PPO Members reach their MOOP limit, they will have no liability for the remainder of the calendar year for Medicare Part A and B claims.

  Use PEAR PM to check all Medicare Advantage HMO and PPO Members' benefits as they relate to cost-sharing for every office visit.

Independence routinely audits the claims we adjudicate to ensure they are paid accurately and in accordance with the Member's benefit plan. Audits include, but are not limited to, ensuring appropriate application of cost-sharing.

Hospital Referrals

Commercial Members: When referring Members for a surgical procedure or hospital admission, the PCP needs to issue only one Referral to the specialist or attending/admitting Physician. This Referral will cover all facility-based (i.e., hospital, ASC) services provided by the specialist or attending/admitting Physician for the treatment of the Member's condition. The Referral is valid for 90 days from the date it was issued. The admitting Physician should obtain the required Preapproval/Precertification. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval/Precertification. Please ensure the Referral, when required, is on file to the specialist or attending/admitting Physician prior to rendering the surgical/outpatient procedure or other outpatient service or your facility-based portion of the claim may be denied for lack of Referral.

Medicare Advantage Members: Referrals are no longer required for Medicare Advantage HMO Members. However, the admitting Physician still must obtain the required Preapproval/Precertification. Any pre-admission testing and hospital-based Physician services (e.g., anesthesia) will be covered under the hospital or surgical Preapproval/Precertification.

CMS prohibits preapproval/precertification for out-of-network services on PPO products.

Note: Certain products have specialized Referral and Preapproval/Precertification requirements and/or benefits exemptions.

Member consent for financial responsibility

The *Member Consent for Financial Responsibility Form* is used when a Member does not have a required Referral for nonemergency services or elects to have services performed that are not covered under his or her benefits plan. By signing this form, the Member agrees to pay for noncovered services specified on the form. The form must be completed and signed before services are provided.

The form is available on our website at *www.ibx.com/providerforms*. This form does not supersede the terms of your Agreement, and you may not bill Members for services for which you are contractually prohibited.

Note: If an HMO or POS Member presents without a Referral, the Provider should request that the Member completes a financial responsibility form.

Medicare Advantage HMO and PPO Members

Providers must give Keystone 65 HMO and Personal Choice 65℠ PPO Members written notice that noncovered/excluded services are not covered and that the Member will be responsible for payment before services are provided. The notice must contain the specific services that are not covered. A generalized waiver form is not acceptable. Should a Member file an appeal, CMS requires that we include confirmation that the Member was informed in advance that the services are not covered. If the Provider does not give written notice of noncovered/excluded services to the Member, then he or she is required to hold the Member harmless.

Product offerings

For a complete list of products offered through Independence and the prefixes that correspond to these products, refer to our payer ID grids at *www.ibx.com/edi*.

Some Members have varying cost-sharing and Deductibles based on their plan, (e.g., Flex). Providers are required to use PEAR PM to verify eligibility information.

Preapproval/Precertification guidelines

Preapproval/Precertification is required for certain services prior to services being performed. Examples of these services include planned or elective inpatient admissions and select outpatient procedures.

Refer to the *Clinical Services – Utilization Management* section of this manual for more information on Preapproval/Precertification requirements. Preapproval/Precertification requirements are available on our website at *www.ibx.com/preapproval*.

Note: Preapproval/Precertification is not required for Emergency Services.

Provider Engagement, Analytics & Reporting (PEAR) portal

The PEAR portal offers Providers a single point of entry to access multiple digital tools. It was designed to connect Providers quickly and securely to the plan information they need to deliver high-quality care. Through the various applications within the PEAR portal, Providers can easily access the clinical and financial information specific to their provider organization and plan contracts.

PEAR PM

PEAR Practice Management (PM) is a provider engagement application that connects Providers to the Plan information and transactions that Providers use every day to help deliver high quality care for Members. PEAR PM seamlessly supports Provider's daily interactions to ensure a more streamlined and user-friendly experience, all through a single sign-on to the PEAR portal. PEAR PM allows easy access to many transactions such as:

- member eligibility and benefits
- submission, search, and investigation of claims
- submission and search of authorizations
- submission and search of referrals

PEAR AR

PEAR Analytics & Reporting (AR) is an on-demand provider reporting application that allows Providers to review and compare their practice's performance with peers and identify gaps in care and opportunities for improvement. A variety of entity-level reports and dashboards provide a real-time view of data specific to each Provider or organization. PEAR AR also provides access to view provider incentive payment rosters.

Self-service requirements

All Participating Providers, facilities, Magellan-contracted Providers, and billing agencies that support Provider organizations are required to have PEAR portal access and must complete the tasks listed below using PEAR PM.

- **Eligibility and claims status.** All Participating Providers and facilities are required to use PEAR PM to verify Member eligibility and obtain Independence claims status information. The claim detail provided through PEAR PM includes specific information, such as check date, check number, service codes, paid amount, and Member responsibility.
- **Authorization Submission.*** All Participating Providers and facilities must use PEAR PM in order to initiate the following authorization types: ambulance (land) – non-emergent ambulance transportation (*Note:* Except for ambulance land requests from a facility as part of discharge planning.), chemotherapy, durable medical equipment – purchase and rental, Emergency hospital admission notification, home health (dietitian, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, infusion therapy, and medical/surgical procedures, and specific outpatient physical therapy and occupational therapy services for Medicare Advantage members.

  Requests for medical/surgical procedures can be made up to six months in advance on PEAR PM. In most cases, requests for Medically Necessary care are authorized immediately; however, in some cases authorization requests may result in a pended status (e.g., when additional clinical information is needed or when requests may result in a duplication of services). PEAR PM submissions that result in a pended status can vary in the time it takes for completion. If an urgent request (i.e., procedure or admission for the same or next day) results in a pended status, please call 1-800-ASK-BLUE for assistance.

  Note: If the authorization is in a pended status, it is not yet approved. Providers should not submit any claims or claim inquiry requests that relate to the pended authorization until it has an approved status of “certified.” If claims are submitted prior to the authorization being approved, they may be rejected.
- **Claim adjustment request or inquiry.** Providers who call Customer Service to question a claim payment or to request a claim adjustment will be directed to submit the request via PEAR PM using the Claim Search transaction. Requests can be submitted for dates of service up to 18 months prior to the current date of service.

EFT requirement

All participating Providers must register for and maintain electronic funds transfer (EFT) capability for the payment of claims, capitation, and incentive-based programs. EFT registration enables a direct electronic payment from Independence to the Provider’s bank account.

The benefits of EFT

There are several benefits of using EFT over conventional paper-based methods, including:

- higher security
- faster access to funds
- reduced administrative processing time

Registration details

Registration for EFT must be completed through PEAR PM by an individual who is authorized to access and maintain banking information for your organization. This individual will be required to attest as the designated responsible party when first accessing the EFT registration screen.

Out-of-area and FEP Members

Through the BlueExchange® Out of Area transaction on PEAR PM, Providers can review claims status, view eligibility and benefits information, and make Referral/authorization submissions for out-of-area Members. Providers can also view eligibility and benefits information for FEP members on PEAR PM within the BlueExchange Out of Area transaction section.

The following are other transactions available through the BlueExchange Out of Area menu option:

- **BlueCard® Coordination of Benefits.** This transaction links you to the BlueCard COB Questionnaire that should be completed by all out-of-area Members prior to rendering service to streamline claims processing and expedite payment to Providers.
- **Medical Policy/Pre-Certification Inquiry.** This transaction allows Providers to obtain information regarding the Home Plans' medical policy and Preapproval/Precertification requirements just by entering the prefix of the out-of-area Member.
- **Pre-Service Review for Out-of-Area Members.** Through this transaction, Providers can access the Provider portal of an out-of-area Member's Home Plan and conduct electronic pre-service reviews. Users may still need to call the Member's Home Plan to request Preapproval/Precertification if the Home Plan does not offer the pre-service review electronically.

PEAR Organization Administrators

The PEAR Organization Administrator is your office's primary contact with PEAR regarding security issues with the portal. Offices must designate at least one PEAR Organization Administrator, and may have two. The Organization Administrator also interacts with Location Administrators and End Users in your office and with Independence to ensure that users are getting the most out of PEAR.

HIPAA mandates that each Provider office designate an Organization Administrator to be aware of the electronic storage and transmission of patient information within and from your office.

Roles and responsibilities

A PEAR Organization Administrator is responsible for making sure that PEAR is used in a HIPAA-compliant way. He or she is also responsible for configuring Providers, users, and permissions so the office can use PEAR effectively and efficiently.

To fulfill these responsibilities, the Organization Administrator undertakes several special tasks, including:

- ensuring that every staff member who accesses PEAR has his or her own unique user name and password;

- ensuring that user names and passwords are not shared with anyone else in the office;
- adding, reactivating, deactivating, and terminating PEAR Location Administrators and End Users in the office, when appropriate;
- resetting user passwords;
- notifying Independence if someone else takes on the role of Organization Administrator;
- setting transaction permissions for individual users;
- making sure the office is registered to all applicable health plans;
- making sure the office has the right tax ID numbers, groups, and Providers available for PEAR transactions.

For more detailed information on common PEAR Organization Administrator tasks and best practices, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

PEAR resources

Training materials are available on the PEAR Help Center at *www.pearprovider.com*. If you need technical assistance, please contact the PEAR Support Line at 1-833-444-7327.

**This information does not apply to Providers contracted with Magellan Healthcare, Inc. (Magellan). Magellan-contracted Providers should contact Magellan at 1-800-688-1911 to request an authorization.*

iEXCHANGE®

Independence Administrators, which offers third-party administration services to self-funded health plans based in the Philadelphia region and has plan Members throughout the U.S., provides you with an additional online service called iEXCHANGE, a MEDecision product. iEXCHANGE supports the direct submission and processing of health care transactions, including inpatient and outpatient authorizations, treatment updates, concurrent reviews, and extensions. This online service is offered through AmeriHealth Administrators, an independent company that provides medical management services for Independence Administrators. Certain services require Preapproval/Precertification to ensure that your patients receive the benefits available to them through their health benefits plan. With just a click of a mouse, you can log into iEXCHANGE, complete the Preapproval/Precertification process, and review treatment updates.

Available transactions:

- inpatient requests and extensions
- other requests and extensions (outpatient and ASC)
- treatment searches
- treatment updates
- Member searches

After registering, you can also access iEXCHANGE through PEAR PM for Independence Administrators plan Members. For more information or to get iEXCHANGE for your facility, go to *www.ibxtpa.com/providers* or contact the iEXCHANGE help desk at Independence Administrators by calling 1-888-444-4617.

Provider Automated System

The Provider Automated System enables Providers to retrieve the following information by following a series of self-service voice prompts and questions specific to your inquiry:

- **Eligibility.** Check coverage status, effective dates, and group name information.
- **Benefits.** Verify Copayment, Coinsurance, and Deductible information.
- **Claims.** Obtain paid status, claim denial reasons, paid amount, and Member responsibility information.

Note: For authorizations, Providers should enter and retrieve information through PEAR PM.

To access the Provider Automated System, call 1-800-ASK-BLUE and say "Provider" or press 1 when prompted. Once in the Provider Automated System, you will need to have your National Provider Identifier (NPI) or tax ID number, as well as the Member's information (Member ID number and date of birth), ready in order to access the requested information.

A user guide for the Provider Automated System is available at *www.ibx.com/providerautomatedsystem*.

Submitting claims

This section contains general information about claims submission for hospital, ancillary facility, and ancillary Providers. For more detailed information about claims submission for specific services, please refer to either the *Billing & Reimbursement for Hospital Services* or the *Billing & Reimbursement for Ancillary Services* section of this manual, as appropriate.

Be sure to visit our website at *www.ibx.com/edi* for information on claims submission and billing and tools related to these activities. This site makes it easy to find important claims-related information and provides access to electronic billing guidelines, HIPAA Transaction Standard Companion Guides, payer ID grids, and claim form requirements.

Claims submission for Independence Members

If you are a Participating Provider with Independence submitting claims for Independence commercial HMO, POS, and PPO and Medicare Advantage HMO and PPO Members, you must submit the claim directly to Independence. This requirement applies both to Providers in the Independence five-county service area (i.e., Bucks, Chester, Delaware, Montgomery, and Philadelphia counties) and Providers located in contiguous counties (i.e., counties that surround the Independence five-county service area).

Claims for Independence Members may ***not*** be submitted to a local plan if the Provider is contracted with Independence. For example, an Independence-Participating Provider located in Camden County, New Jersey (i.e., a contiguous county) should not submit a claim to Horizon Blue Cross Blue Shield of New Jersey for an Independence Member. Rather, he or she should submit the claim directly to Independence.

If an Independence-Participating Provider attempts to submit a claim to their local plan for an Independence Member, the claim will be denied. No payment will be issued by Independence until the claim is correctly submitted to Independence.

Electronic Data Interchange claims submission

Electronic Data Interchange (EDI) claims submission is the most effective way to submit your claims. EDI claims submission reduces payor rejections and administrative concerns and increases the speed of claims payment by submitting HMO, PPO, and POS claims

electronically. If you are in need of EDI support for Independence claims, Highmark EDI Operations is your first point of contact. Highmark EDI Operations is available at 1-800-992-0246, Monday through Friday from 8 a.m. to 5 p.m., ET. Additional EDI billing information can be viewed online at *www.ibx.com/edi*.

Claims submission requirements

For Providers who bill electronically, refer to the claims submission requirements found in the Companion Guides at *www.ibx.com/edi*. Independence recommends that you share our electronic billing requirements and updates with your billing vendor.

For Providers who bill on paper, please refer to the following:

- **UB-04 claim form.** Facility Providers who bill on paper should use a UB-04 claim form. Refer to the *UB-04 claims submission guide* for details on how to complete a paper UB-04 claim form, which is available at *www.ibx.com/providers/claims_and_billing/claims_resources_guides.html*.
- **CMS-1500 claim form.** The CMS-1500 claim form should only be used by ancillary Providers, such as home infusion, DME, ambulance, and private duty nursing. For more information on submitting CMS-1500 claim forms, refer to the *CMS-1500 claims submission toolkit*, available at *www.ibx.com/providers/claims_and_billing/claims_resources_guides.html*.

Failure to use the correct claim form for the services being billed will result in the claim being returned to you or claim denial.

Clean Claim

A Clean Claim is a claim for payment for a Covered Service provided to an eligible Member on the date of service, accepted by Independence's EDI system as complete and accurately submitted, and consistent with the Clean Claim definition set forth in applicable federal or State laws and regulations.

The following information is generally required for a Clean Claim:

- patient's full name
- patient's date of birth
- valid Member ID number, including prefix
- statement "from" and "to" dates
- diagnosis codes
- facility bill type
- revenue codes
- procedure codes (e.g., CPT® at the line level for Outpatient claims, ICD-10-CM at the claim level for Inpatient claims)
- charge information and units
- service Provider's name, address, and National Provider Identifier (NPI)
- Provider's TIN

For proper claims processing, please ensure that your billing NPI is affiliated with the entity that submits your electronic claims (e.g., your clearinghouse vendor). If your billing NPI is not affiliated with the submitter, claims will not be accepted for processing and will be rejected.

Missing or incomplete information will result in a claim being returned to you. Claims denied due to missing or incomplete information must be corrected and resubmitted within the time frame specified in your Agreement with Independence in order to be eligible for payment.

Coordination of Benefits/Other Party Liability

Where Independence is determined to be the secondary payor, Independence will reimburse for any *remaining* balance, not paid by the primary carrier, *only* up to and including its own fee schedule or contracted rate, excluding applicable Deductibles, Copayments, and Coinsurance. If the primary carrier paid more than Independence would have paid had it been the primary carrier, no additional payment will be made, and the Member may not be billed. As a result, the total of the primary carrier's payment plus any balance paid by Independence will never exceed the contracted rate of payment.

Motor vehicle accident

All claims, up to the appropriate auto benefits amount related to the motor vehicle accident (MVA), are coordinated with the auto insurance carrier.

- To expedite payment, the Provider should bill the auto insurance carrier first.
- When the auto insurance carrier sends notice that the applicable auto benefits have been exhausted, the Provider should submit an exhaust letter with each claim form that is submitted to ensure prompt payment and to avoid a timely filing denial.
- Members should not be billed or be required to pay before MVA-related services are rendered.

Workers' compensation

If a claim is related to a workers' compensation accident, the Provider must bill the workers' compensation carrier first and conditionally bill Independence to avoid a timely filing denial. If the workers' compensation carrier denies the claim, the Provider should submit the bill to Independence with a copy of the denial letter attached to the claim.

To expedite payment, include the following information when filing a workers' compensation claim:

- Member's name
- Member's ID number
- date of accident
- name and address of workers' compensation carrier

Submitting COB information

Facilities can submit Coordination of Benefits (COB) information electronically for facility services using the applicable 837I format. For instructions on how to bill electronically, visit *www.ibx.com/edi*.

Submitting COB information electronically eliminates the need for paper claims submissions. Claims submitted electronically are processed faster and have a significantly higher "first pass" adjudication rate, which translates into a faster payment.

COB for dependents

Independence processes COB claims for dependents of Members with different coverage plans according to the "birthday rule." If both parents have family coverage with two different health plans, the parent whose birthday falls nearest to January 1 is the primary insurance carrier.

> **Example:** If the mother's birthday is January 30 and the father's birthday is March 1, the mother's plan is primary.

Exceptions to the "birthday rule" may apply under certain conditions, including but not limited to, where required by divorce decree, child custody, or other court order.

HIPAA 5010 and ICD-10

- **HIPAA 5010.** The U.S. Department of Health and Human Services (HHS) stipulates that any health care entity that submits electronic health care transactions, such as claims submissions, eligibility, and remittance advice, must comply with the X12 Version 5010 standards. HIPAA 5010 Companion Guides are available at *www.ibx.com/edi* to assist you in submitting HIPAA 5010-compliant transactions.
- **ICD-10.** HHS requires the use of International Classification of Diseases, 10th Revision (ICD-10) on all claims. Visit *www.cms.gov/icd10* for more information.

Medicare Advantage PPO claims processing

Independence will process BCBSA plan Medicare Advantage enrollee claims for covered professional, facility, and ancillary services (ambulance, DME, and home infusion) in the five-county service area in accordance with your contracted rates.

Overpayments

If you identify an erroneous overpayment when reviewing your Provider Remittance and reconciling it against a Member account, log on to PEAR PM, and begin a Claim Investigation using the Claim Search transaction.

Updating your Provider information

Accurate data files allow us to continue to provide you with important information on billing, claims, changes or additions to policies, and announcements of administrative processes. You are contractually required to notify us in a timely manner when changing key Provider demographic information.

Independence requires 30 days advance written notice to process the following changes to your information:

- updates to address, phone number, or fax number;
- adding or removing Providers from your panels (either newly credentialed or participating).

Note: Independence will not be responsible for changes not processed due to lack of proper notice from the Provider. Failure to provide proper advance written notice to Independence may delay or otherwise affect Provider payment.

All changes must be submitted in writing to our contracting and legal departments at the following addresses, or as provided in your Agreement:

> Independence Blue Cross
> Attn: Senior Vice President, Total Value Contracting and Reimbursement
> 1901 Market Street, 27th Floor

Philadelphia, PA 19103

Independence Blue Cross
Attn: Deputy General Counsel, Managed Care
1901 Market Street, 43rd Floor
Philadelphia, PA 19103

Authorizing signature and W-9 Forms

Written notification on company letterhead is required for any changes that may result in a change on your W-9 Form, including changes to a Provider's name, tax ID number, billing vendor or "pay to" address, or ownership. An updated copy of your W-9 Form reflecting these changes must also be included to ensure that we provide you with a correct 1099 Form for your tax purposes. If you do not submit a copy of your new W-9 Form, your change will not be processed.

Compliance training for Medicare programs

CMS requires all first-tier, downstream, and related entities (FDR) complete the following courses, which are available through the Medicare Learning Network (MLN):

- Medicare Parts C and D General Compliance Training
- Combating Medicare Parts C and D Fraud, Waste, and Abuse

An FDR is defined by CMS as a party that enters into a written agreement to provide administrative services or health care services to a Medicare enrollee on behalf of a Medicare Advantage or Part D plan. FDRs include, but are not limited to, contracted health care Providers, pharmacies, suppliers, and vendors.

As a Provider of health care services for Independence Medicare Advantage and Medicare Part D Prescription Drug Program (Medicare Part D) Members, you and your staff are expected to comply with CMS requirements by completing this training. Please visit the Medicare Learning Network at *www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf* to access and complete your Medicare compliance training at the time of hire and annually thereafter.

We suggest that you and your staff maintain records of completion.