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Overview

The purpose of this section is to describe the specific billing and Preapproval/Precertification requirements for services rendered by ancillary facility and ancillary professional Providers and to supplement the General Information and Administrative Procedures sections.

Many of the services in this section of the manual require Preapproval/Precertification. A list of current Preapproval/Precertification requirements by product is available online at *www.ibx.com/preapproval*. These requirements vary by benefits plan and are subject to change. Any additional requirements specific to a certain type of service are listed under that service category.

General billing guidelines

Electronic billing (837P or 837I)

National Association of Insurance Commissioners (NAIC) codes

All claims submitted electronically must be submitted with the NAIC codes for the line of business identification. Please view the appropriate payer ID document at *www.ibx.com/edi* for a complete list of the NAIC-assigned codes.

Providers have up to twelve (12) months following the date of service to submit claims.

When billing through Electronic Data Interchange (EDI), claims may be submitted through a vendor that you are contracted with or directly to Independence through your own computer system. Claims are submitted in batches and may be sent daily or weekly, depending on your claims volume. If you submit claims electronically, you will receive a 277 Claims Acknowledgement (277CA). The error description on the 277CA will aid you in correcting and resubmitting to ensure an expedited remittance.

All professional and facility provider claims for Blue High Performance Network℠ (Blue HPN) members must be submitted to Independence.

For submission instructions, please refer to the appropriate Companion Guide at *www.ibx.com/edi*. If you have questions about an electronic claims submission, please contact Highmark EDI Operations at 1-800-992-0246.

Paper billing

If you must submit a claim on paper, you will need to use the CMS-1500 or UB-04 claim form, as specified in the remainder of this section based on the type of service you provide.

Usual, Customary, and Reasonable charges

All claims must be submitted with Usual, Customary, and Reasonable charges and in accordance with billing requirements specified by type of service as listed below.

Split billing

Independence requires that professional claims be billed on one CMS-1500 claim form or electronic 837P transaction when two or more procedures or services were performed for the same patient, by the same performing Provider, and on the same date of service. When services rendered on the same date, by the same Provider are billed on two claims, it is defined as “split-billing.”

Providers must bill on one claim form for all services performed on the same day, for the same patient, unless there is an Independence policy that supports split-billing for the services or

procedures performed. Failure to do so prohibits the application of all necessary edits and/or adjudication logic when processing the claim. As a result, claims may be under- or over-paid and Member liability may be under- or overstated.

Enhanced Claim Editor Program

Claims received by Independence are subject to a claim editing process during prepayment review.* The Enhanced Claim Editing Program is one of many programs in place dedicated to ensuring claims are billed accurately and in accordance with industry standard coding principles. The program includes Automated Edits and Coding Validator reviews:

- **Automated Edits** are systematic edits automatically applied based on coding rules
- **Coding Validator** reviews are denials based on a thorough review of the claim coding by a Registered Nurse who is also a Certified Professional Coder (CPC) against pertinent information billed on the claim and the claims in the member's history.

The Enhanced Claim Editing Program supports our commitment to ensure compliance with correct coding principles as endorsed by national and regional industry sources, including but not limited to:

- Centers for Medicare & Medicaid Services (CMS) standards such as:
  - National Coverage Determinations (NCDs)
  - Local Coverage Determinations (LCDs)
  - Medicare Claims Processing Manual
  - Durable Medical Equipment Regional Carries (DMERC) Manual
  - CMS HCPCS LEVEL II Manual coding guidelines
- American Medical Association (AMA) Current Procedural Terminology (CPT®) coding guidelines
- ICD-10-CM Official Guidelines for Coding and Reporting
- Food and Drug Administration (FDA)
- Nationally recognized specialty societies such as:
  - National Comprehensive Cancer Network (NCCN)
  - American College of Obstetricians and Gynecologists (ACOG):
  - U.S. Preventive Services Task Force (USPSTF)

Please be advised that as guidelines from these sources are updated, our claim edits will be reviewed, and additional claim edits will be implemented as applicable.

**Self-funded groups have the option to not participate in the enhanced claim edits; therefore, your outcomes may vary by health plan.*

Areas of focus

Independence's correct coding principles focus on the following areas, but are not limited to:

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) coding and reporting guidelines including:
  - "Code Also" and "Code First" instructional notes
  - Principle/first listed and secondary only diagnosis codes

  - Inappropriate use of unspecified codes
- National bundling guidelines including:
  - CMS National Correct Coding Initiative (NCCI) edits and NCCI Policy Manual guidelines
  - AMA unbundling guidelines
  - Global surgery guidelines
- Modifier Usage including:
  - Appropriate reporting of modifiers including but not limited to: 59, GN, GO, GP, LT, RT, TC, XE, XP, XS, XU, etc.
  - CMS modifier requirements for durable medical equipment (DME) and prosthetics and orthotics (P&O)
  - Reporting of an override modifier on procedures subject to NCCI edits with a modifier override allowed
- Add-On codes
- Medically Unlikely Edits (MUE)
- Injectable drugs and biological agents including:
  - Consistency of diagnosis codes with FDA-approved labeling indications and approved off-label indications
  - Reporting diagnosis codes in accordance with ICD-10-CM coding guidelines
  - Dosage and frequency of administration appropriate for reported diagnosis

Identifying Automated Edits vs Coding Validator reviews

Automated Edits are systematic edits automatically applied based on coding rules, whereas Coding Validator reviews are denials based on a thorough review of the claim coding by a Registered Nurse who is also a Certified Professional Coder (CPC) against pertinent information billed on the claim and the claims in the Member's history.

If your claim was affected by the Enhanced Claim editor, the edit explanation will be displayed on your electronic remittance report (835) and/or paper Provider Explanation of Benefits (EOB) or Facility Remittance. Unique alpha-numeric codes and messages have been created that begin with E8.

A Coding Validator edit claim line will contain an E819X denial, all other E8XXX codes/messages are Automated Edits. You can also find the E8XXX codes/messages within PEAR Practice Management (PM) using the Claim Search transaction. From the Claim Details screen, if there is an E8XXX code, a Claim Editor link will appear. This link will show further detail in the Rationale and Description. This is an additional indication that the edit is related to Coding Validation and is not an Automated Edit. Only E8XXX codes/messages are part of the Enhanced Claim Editor program. All other codes/messages are unrelated to the program.

Denial Dispute Processes

To request a claim review of a Coding Validator edit or dispute a denial from an Automated edit, please follow the appropriate process for the applicable edit as described below.

Request for Coding Validator claim review

While you may use PEAR PM to view detailed information on a Coding Validator E819X denial, clinical information needs to be submitted to dispute the denial. The clinical information should include all applicable medical records, notes, and tests along with a cover letter explaining the reason for the dispute.

To facilitate a review, submit the documents listed above via:

- Email: *claimcodingvalidation@ibx.com*
- Mail:

  Independence Blue Cross
  Claim Coding Validation
  1901 Market Street
  Philadelphia, PA 19103

Request for an Automated Edit claim review

For all other E8XXX edits related to Automated Edits, Providers should submit a Claim Investigation through the Claim Search transaction in PEAR PM to ask questions or request an adjustment. Please provide any additional information including reference claim numbers or corrections submitted to support your request for reconsideration for approval.

Claims submission for CHIP members

The Pennsylvania Department of Human Services (DHS) requires all Children's Health Insurance Program (CHIP) to have a PROMISe ID for **each location** at which they treat CHIP Members. Additionally, the Facility, Rendering, and Ordering Providers billed on a claim must have a PROMISe ID. The PROMISe ID is a requirement to for Providers to receive payment for services rendered to CHIP Members. Claims submitted without a PROMISe ID will be denied.

Billing guidelines by type of service

Ambulance services

Preapproval/Precertification requirements

- Preapproval/Precertification is required for all non-emergent ambulance transport.
- Transfers from a medical facility to a mental health facility by ambulance must be Preapproved/Precertified by Magellan Healthcare, Inc., an independent company.

Billing information

Participating ambulance Providers must submit claims using the 837P (electronic) or CMS-1500 claim form (paper). Please also note the following billing requirements specific to ambulance Participating Providers:

- The National Provider Identifier (NPI) assigned to your organization must appear on every claim.
- The appropriate modifier(s) that describe the transport should be included on every claim submission.
- Only those services specified in your Hospital, Ancillary Facility, or Ancillary Provider Agreement (Agreement) will be reimbursed.

- Ambulance Providers must include ZIP code information on all ambulance service claims:
  - **Electronic claims.** If you bill electronically via HIPAA 5010, please include both the pick-up and drop-off ZIP codes in the appropriate fields.
  - **Paper claims.** If you bill claims on paper, please include the pick-up ZIP code in box 23 of the CMS-1500 claim form. The ZIP code is the only data element that should be included in that field.

For additional information on ambulance services, please refer to our medical policies at *www.ibx.com/medpolicy*.

Ambulatory surgical center services

Preapproval/Precertification requirements

Preapproval/Precertification by Independence is based on the code for the planned procedure, but the code assigned for billing after the procedure may be different. If the codes are not "reasonably related", then an updated Preapproval/Precertification may also be required.

Example:

> Procedure code 12345 was Preapproved/Precertified. The code assigned for billing is 54321. However, code 54321 is not "reasonably related" to the originally requested procedure code. As the Preapproval/Precertification was for code 12345, there is no Preapproval/Precertification on file for code 54321, and the Provider would need to submit a request to update the Preapproval/Precertification to reflect code 54321.

Billing information

Participating ambulatory surgical centers (ASC) must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to ASCs:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- Preapproval/Precertification authorization numbers, if applicable, should appear in field locator 63.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- The correct bill type, 83X, must be used. If the bill type does not correspond with your Provider type, the claim will be rejected and returned to you.
- A "no-pay" bill must also be sent to the fiscal intermediary for Keystone 65 HMO or Personal Choice 65^{SM} PPO Members.

Revenue codes

ASCs should use the following revenue codes for surgery claims: 0360, 0361, 0362, 0367, 0369, 0481, 0490, 0499, 0519, 0750, 0769, and 0790. The same revenue code should be used for each surgical procedure. When Providers bill with different revenue codes, there is no additional reimbursement.

Inclusions and exclusions

ASC Surgery Fee Schedule reimbursements are made on a per-service basis only for those services included on the fee schedule. The ASC shall be reimbursed in accordance with Independence's Medical policies and in accordance with the terms of their Agreement. To the

extent that any of the policies conflict with the Agreement, the terms of the Agreement shall govern.

Note: For ASC's contracted on the Hospital Outpatient Surgical fee schedule see Billing & Reimbursement for Hospital Services – Outpatient Surgery Reimbursement for discontinued or cancelled surgeries.

When a planned surgery is cancelled before it began or discontinued before the surgery is completed, the services may be eligible for reimbursement. When some of the services related to the intended procedure have been rendered, such as the administration of anesthesia or the insertion of the scope, the hospital/facility may be eligible to receive reimbursement for the planned surgical service. The scenarios eligible for reimbursement are for procedures discontinued or cancelled for reasons beyond the ASC's control, such as the patient develops an arrythmia or the patient's blood pressure suddenly drops. For these circumstances, the ASC will be reimbursed at 50 percent of the contracted fee schedule rate. Procedures that are cancelled due to administrative reasons (e.g., equipment failure, staffing problems) will not be eligible for reimbursement consideration.

Coding and billing requirements:

- Report the HCPCS and/or CPT code for the intended procedure.
- Report the principal diagnosis code, which is the reason for the surgery.
- Report as the secondary diagnosis code the appropriate ICD-10-CM code indicating cancelled or discontinued surgery.
- Report the appropriate modifier if applicable (i.e., Modifier 73 or 74).

Birthing centers

Participating birthing centers must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to birthing centers:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- A charge amount must appear in the total charge field for each line item. Lines with zero-dollar charges will not be accepted. The amount billed must be greater than zero.
- The correct bill type, 84X, must be used. If the bill type does not correspond with your Provider type, the claim will be rejected and returned.

Dialysis centers

Billing information

Participating dialysis centers must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to dialysis centers:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.
- The correct bill type, 72X, must be used. If the bill type does not correspond with your Participating Provider type, the claim will be rejected and returned to you.

- A charge amount must appear in the total charge field for each line item. Lines with zero-dollar charges will not be accepted. The amount billed must be greater than zero.
- All bills must be submitted on a monthly basis.
- Referrals for HMO Members are not required.
- To ensure correct claim payment, please use the following revenue codes when billing for services rendered in accordance with your Agreement:

Revenue code (UB-04 field locator 42)	UB-04 description (field locator 43)
0821	Hemodialysis
0825	Hemodialysis with training
0829	Home dialysis training and treatment
0831	Peritoneal dialysis
0835	Peritoneal dialysis with training
0841	CAPD dialysis
0845	CAPD dialysis with training
0851	CCPD dialysis
0855	CCPD dialysis with training

Billing procedures

The following requirements for submitting claims to Independence for renal dialysis services are based on Medicare's billing instructions (National Uniform Billing Committee/HCFA). For your claims to be accepted and processed by Independence, the billing requirements defined below must be used.

Note: Follow the coding guidelines in the current UB-04 and ICD-10-CM/CPT manuals when reporting all services.

HCPCS/CPT codes: HCPCS/CPT codes are required when reporting services in the following series of revenue codes:

30X	31X	32X	73X	92X
82X	83X	84X	85X	636

Notice of Medicare coverage

Upon enrollment of any Independence Member, participating dialysis centers must submit to Independence a copy of the Medicare HCFA-2728 form that is sent to the Renal Networks. These forms are needed to facilitate our Member reconciliation efforts with the Centers for Medicare & Medicaid Services (CMS) and to ensure appropriate coordination of benefits. Please submit forms for Independence Members covered under all products referenced in this manual to:

Independence Blue Cross
27th Floor
1901 Market Street
Philadelphia, PA 19103-1480

Please refer to the General Information section of this manual for claims information.

Durable medical equipment

Preapproval/Precertification requirements

Preapproval/Precertification is required for the following durable medical equipment (DME):

- bone growth stimulators
- bone-anchored hearing aids
- continuous positive airway pressure (CPAP) devices, bi-level (Bi-PAP) devices, and all supplies*
- dynamic adjustable and static progressive stretching devices (excludes CPMs)
- electric, power, and motorized wheelchairs including custom accessories
- external defibrillator and associated accessories
- high frequency chest wall oscillation generator system
- manual wheelchairs with the exception of those that are rented
- negative pressure wound therapy
- neuromuscular stimulators
- power operated vehicles (POV)
- pressure reducing support surfaces including:
  - air fluidized bed
  - non powered advanced pressure reducing mattress
  - powered air flotation bed (low air loss therapy)
  - powered pressure reducing mattress
- push rim activated power assist devices
- repair or replacement of all DME items, as well as orthoses and prosthetics that require Preapproval/Precertification
- speech generating devices

**Preapproval/Precertification performed by Carelon Medical Benefits Management (Carelon), an independent company.*

Billing information

Participating DME Providers must submit claims using the 837P (electronic) or CMS-1500 claim form (paper). Please also note the following billing requirements specific to DME Providers:

- The NPI assigned to your organization must appear on every claim.
- The “from” and “to” dates of care must be provided.
- Modifiers must be reported for DME & P&O in accordance with the CMS billing requirements and guidelines. Examples for commonly reported modifiers and the reporting requirements:

Modifier	Requirements
A1-A9, GY	All surgical dressings billed by a DME provider require a modifier indicating the number of wounds on which the surgical dressing was used. Modifiers A1 – A9 have been established to indicate that a particular item is being used as a primary or secondary dressing on a surgical or debrided wound and also to indicate the number of wounds on which that dressing is being used. The modifier number must correspond to the number of wounds on which the dressing is being used and not the total number of wounds treated. When a dressing is provided in a noncovered situation, Modifier GY must be added to the code. Additionally, when tape is furnished in conjunction with a surgical dressing (Modifier AW), Modifier A1 – A9 is required to be appended to codes indicating the number of wounds being treated.
AU, AV, AW, and AX	Modifiers have been established for use when items are furnished in conjunction with various supplies listed in multiple durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit categories, DME MAC Local Coverage Determinations (LCD), and Related Policy Articles (PA) such as tape. These modifiers identify items that are eligible for reimbursement under multiple benefit or payment categories: • AU: Item furnished in conjunction with a urological, ostomy, or tracheostomy supply. • AV: Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic. • AW: Item furnished in conjunction with a surgical dressing. • AX: Item furnished in conjunction with dialysis services.
CG	Spinal orthoses billed without Modifier CG (Policy criteria applied) or GY (Item or service statutorily excluded or does not meet the definition of any Medicare benefit) is inappropriate. Additionally, Hand and Finger orthoses reported without Modifier CG (Policy criteria applied) is also inappropriate.
FA – F9 and TA – T9	When a finger or toe device is reported, the presence of a specific finger Modifier FA – F9 or a specific toe Modifier TA – T9 to indicate the anatomic site being treated is required.
K0 – K4	Functional modifiers have been developed to define ability. A lower limb prosthesis must be billed with one of the functional modifiers. Functional modifiers: • K0: Does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthesis does not enhance their quality of life or mobility. • K1: Has the ability or potential to use a prosthesis for transfers or ambulation on level surfaces at fixed cadence. Typical of the limited and unlimited household. • K2: Has the ability or potential for ambulation with the ability to traverse low level environmental barriers such as curbs, stairs, or uneven surfaces. Typical of the limited community ambulator.

	• K3: Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple location. • K4: Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.
KS, KX	Home glucose monitors must be appended with Modifier KS (Glucose monitor supply for diabetic beneficiary not treated with insulin) or Modifier KX (Documentation on file) to indicate whether the patient is insulin dependent.
KX, GA, or GZ	Certain DME must be billed with Modifier KX if all of the indications and coverage limitations criteria have been met. This includes but is not limited to: • controlled dose inhalation drug delivery system • multi-positional patient transfer system • ultrasonic/electronic aerosol generator with small volume nebulizer • hospital bed • power mobility device • seat and back cushions and positioning accessories • respiratory assist device (RAD) or airway pressure device • custom oral appliance for obstructive sleep apnea (OSA) • external insulin infusion pumps and insulin for use with DME • form fitting conductive garment for delivery of TENS • knee orthosis and Orthotic additions • heavy duty walker • orthopedic footwear and the associated inserts or modifications • negative pressure wound therapy pumps • urological supplies • anti-reflective coating, polycarbonate or Trivex® lenses, tints, or oversized lenses • high frequency chest wall oscillation device • oxygen and oxygen equipment If all of the criteria have NOT been met, then Modifier GA or GZ must be added to the code and Modifier KX should not be appended.
NU, UE, and RR	Modifier NU represents a new equipment purchase and Modifier UE represents a used equipment purchase. Modifier RR is to be utilized when DME is rented, such as oxygen and oxygen equipment.
RT/LT	For those orthotics or prosthetics that may be billed bilaterally, either Modifier RT (Right) or LT (Left) must be used to define which side is being supported (orthotic) or replaced (prosthetic). It is inappropriate to also include Modifier 50 (bilateral procedure).

Note: The above is not an exhaustive list of modifiers and their reporting requirements.

- A Certificate of Medical Necessity is not required for billing but must be kept on file with the patient's chart to be made available upon request.
- The claim form must show a written description for any miscellaneous billed service that has not been defined or priced.

Note: Subject to state-specific mandates.

Freestanding sleep study centers

Preapproval/Precertification requirements

Preapproval/Precertification is required for HMO Members.

Billing information

Participating freestanding sleep study centers must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to freestanding sleep study centers:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The correct bill type, 89X, must be used. If the bill type does not correspond with your Provider type, the claim will be rejected and returned to your facility.
- Only those services specified in your Agreement will be reimbursed.

In order for a sleep study center to be eligible as an approved sleep study center for Independence's network, the center must be accredited by the Joint Commission or the American Association of Sleep Medicine.

Fee schedule billing and reimbursement

Fee schedules are the method of reimbursement for procedures performed in the sleep study center. Freestanding sleep study centers are reimbursed on a standard fee schedule. Physician services are separately billable.

Habilitative and rehabilitative services

Federal regulations clarified how habilitative and rehabilitative services should be covered by requiring parity in coverage limits for each service and requiring separate visit limits for each. As a result, habilitative and rehabilitative services must be tracked separately for all Members, including out-of-area Members, to ensure visit limits are not combined. Federal regulations define these services as follows:

- **Habilitative services:** Health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, or other services for people with disabilities in a variety of inpatient and/or outpatient settings.
- **Rehabilitative services:** Rehabilitative services, including devices, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Billing information

When billing habilitative services on claims for Independence or out-of-area Members, Providers should use the available HCPCS modifier SZ (Habilitative Services). This billing requirement applies to claims for both professional and outpatient facility services.

Without the SZ modifier, the service will be considered rehabilitative; however, if Providers use the modifier appropriately, Independence and other Blue Plans can track habilitative and rehabilitative services separately and comply with federal regulations.

Home health

All home health services, unless noted otherwise, require Preapproval/Precertification.

Participating home health Providers must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to Participating home health Providers:

- Whether you bill via EDI or on paper, you must complete those fields that are identified as required on the UB-04 Data Field Requirements.
- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The revenue codes listed in this section should be used to bill home health services.
- The correct bill type, 32X, must be used. If the bill type does not correspond with your Participating Provider type, the claim will be rejected and returned to you.
- Include the proper Health Insurance Prospective Payment System (HIPPS) codes on all claims/encounters that come from the initial Outcome and Assessment Information Set (Start of Care Assessment) or OASIS where the "from" date is on or after July 1, 2014. Failure to include the appropriate HIPPS codes will cause your claims to reject.
- Be sure that all the required form fields are completed.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

COVERED SERVICES	
Revenue code	**Description**
0421	Physical therapy, visit charge
0431	Occupational therapy, visit charge
0441	Speech therapy, visit charge
0551	Skilled nursing, visit charge
0561	Medical social worker, visit charge
0571	Home health aide (hourly rate)
0590	Nutrition consultation, visit charge – benefit only for Managed Care benefit programs; not for Traditional (Indemnity) Independence.

Mother's Option®

Please note the following requirements specific to claims for Mother's Option:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- Preapproval/Precertification is not required for the Mother's Option well-mom/baby home care visit, provided that the visit(s) comply with the Mother's Option guidelines.
- The claim should be billed with the mother as the patient, never the baby. If additional visits for the baby are needed, Preapproval/Precertification should be obtained, and the service should be billed under your home health Participating Provider number.

- Preapproval/Precertification is required for all phototherapy services. A separate authorization should be obtained for the skilled nursing visit and for the rental of the Wallaby® blanket.
- Phototherapy claims must always be billed with the baby as the patient.
- The revenue codes listed in this section should be used to bill Mother's Option services.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The correct bill type, 32X, must be used. If the bill type does not correspond with your Participating Provider type, the claim will be rejected and returned to you.
- Be sure that all the required fields are filled in.
- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

For more information, please see the *Clinical Services – Utilization Management* section of this manual.

Note: Self-funded groups are not required to follow any State mandates, including Pennsylvania Act-85. Please verify that a baby has been added to a policy prior to billing phototherapy or standard home care services.

MOTHER'S OPTION®	
Revenue code	**Description for the reported service**
0551	Well-mom/baby, visit charge
0291	Phototherapy (Wallaby rental), daily charge

COVERED DIAGNOSES	
Diagnosis code(s)	**When reporting service**
Z39.2	Well-mom/baby visit
P58 – P59 (neonatal jaundice)	Phototherapy (Wallaby rental)

Perinatal/Baby BluePrints®

Please note the following requirements specific to claims for Mother's Option:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported "statement from" and "statement through" dates.
- The revenue codes listed in this section should be used to bill perinatal services.
- The correct bill type, 32X, must be used. If the bill type does not correspond with your Provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.

- Be sure that all the Member information is correct (e.g., date of birth, relation-to-insured code).

COVERED SERVICES	
Revenue code	**Description**
0551	Skilled nursing, visit charge
0561	Medical social worker, visit charge
0571	Home health aide, hourly charge
0589	Fetal non-stress test, visit charge
0590	Nutrition consultation, visit charge

Home infusion therapy

Participating home infusion Providers must submit claims using the 837P (electronic) or CMS-1500 claim form (paper). Please also note the following billing requirements specific to home infusion Providers:

- Claims must be submitted biweekly or monthly.
- The NPI assigned to your organization must appear on every claim.
- The start and end dates of care must be provided.
- Only those services specified in your Agreement will be reimbursed.
- When more than one antibiotic therapy is administered, it must be reported with the correct approval number assigned for each therapy.
- When reporting hydration therapy, only one rate shall be reimbursable on a per-day basis, regardless of volume used.
- The line maintenance services are reported only when a Member is not receiving active therapy.
- National Drug Code (NDC) numbers are used for determining the average wholesale price (AWP) of the drug component. The AWP is determined using First DataBank pricing. When billing for a drug used in conjunction with infusion therapy, you must use the NDC number of the dispensed drug and the number of units dispensed. Each NDC number must appear on a separate line of the claim form.

All drug claims will require the submission of an accompanying 11-digit NDC. This includes claims for hemophilia Factor products that are currently submitted with specific J codes.

The NDC must be submitted using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (12345678911) will also be accepted. Please *do not* include spaces, decimals, or other characters in the 11-digit string, or the claim will be returned for correction prior to processing.

Private duty nursing

Private duty nursing (PDN) is defined as medically appropriate, complex skilled nursing care in the individual's private residence by a registered nurse or a licensed practical (vocational) nurse. The purpose of PDN is to provide continuous monitoring and observation of a Member who requires frequent skilled nursing care on an hourly basis. In addition, PDN may assist in the transition of care from a more acute setting to home and teaches competent caregivers the assumption of this care when the condition of the Member is stabilized. Please review the

medical policy, which is available at *www.ibx.com/medpolicy*, for more information about Medical Necessity requirements and how PDN differs from a skilled nursing visit.

Participating PDN Providers must submit claims using the 837P (electronic) or CMS-1500 claim form (paper). Please also note the following billing requirements specific to PDN Providers:

- The NPI assigned to your organization must appear on every claim.
- The procedure codes listed in this section must be used in order to ensure proper claims payment.
- Since Preapproval/Precertification is required for the reported service, please complete field locator number 23 on the CMS-1500 claim form.

COVERED SERVICES	
Procedure code	**Description**
S9123	Registered nurse, per hour
S9124	Licensed practical nurse, per hour

Hospice

Preapproval/Precertification requirements

All inpatient hospice services require timely Preapproval/Precertification; however, there is no Preapproval/Precertification requirement for home hospice services (revenue code 0651).

Billing information

Participating hospice Providers must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to hospice Providers:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported “statement from” and “statement through” dates.
- The revenue codes listed in this section should be used to bill hospice services.
- The correct bill type, 81X, must be used. If the bill type does not correspond with your Provider type, the claim will be rejected and returned to you.
- Be sure that all the required form fields are completed.
- Be sure that all Member information is correct (e.g., date of birth, relation-to-insured code).

COVERED SERVICES	
Revenue code	**Description**
0651	Home hospice care, visit charge
0652	Continuous care home hospice (per hour)
0655	Respite care hospice (per day)
0656	Inpatient hospice care (per day)

Independent laboratory

Participating independent laboratory Providers must submit claims using the 837P (electronic) or CMS-1500 claim form (paper). Please also note the following billing requirements specific to independent laboratory Participating Providers:

- The NPI assigned to your organization must appear on every claim.
- Only those service codes specified in your Agreement will be reimbursed.

Lithotripsy centers

Participating lithotripsy centers must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to lithotripsy centers:

- The NPI assigned to your organization must appear on every claim in field locator 56.
- The reported service dates must fall within the reported “statement from” and “statement through” dates.
- The correct revenue code assigned by Independence (0790) must be reported in order to ensure proper claim payment.
- The correct bill type, 83X, must be used. If the bill type does not correspond with your Provider type, the claim will be rejected and returned to you.

Radiation therapy

Preapproval/Precertification for nonemergent outpatient radiation therapy services is required through eviCore healthcare (eviCore), an independent company, for all Commercial and Medicare Advantage HMO and PPO Members. Preapproval/ Precertification is not required when radiation therapy is rendered in the inpatient hospital setting.

Initiate Preapproval/Precertification for nonemergent outpatient radiation therapy in one of the following ways:

- **PEAR PM.** Select *eviCore* from the Transaction tab (under Authorizations).
- **Telephone.** Call eviCore directly at 1-866-686-2649.

For additional information on nonemergent outpatient radiation therapy services, please refer to our medical policies at *www.ibx.com/medpolicy*.

Skilled nursing facility

Billing information

Participating skilled nursing facilities (SNF) must submit claims using the 837I (electronic) or UB-04 claim form (paper). Please also note the following billing requirements specific to SNFs:

- Preapproval/Precertification numbers, when applicable, should appear in box 63.
- The NPI assigned to your organization must appear on every claim in field locator 56.
- Include the proper HIPPS codes on all claims/encounters that come from the initial Omnibus Budget Reconciliation Act (OBRA)-required comprehensive assessment (Admission Assessment) where the “from” date is on or after July 1, 2014. Failure to include the appropriate HIPPS codes will cause your claims to reject.
- To expedite processing, do not submit claims until all charges are identified and included on the claim.

- Miscellaneous HCPCS/CPT codes (codes ending in “99”) are not acceptable.

To assure correct claims payment, utilize the following revenue codes when billing for services rendered:

COVERED SERVICES	
Revenue code	**Description**
0121	Days after Medicare/65 Special
0130, 0150	Basic SNF – Freestanding or hospital-based
0120, 0191	Subacute medical
0129, 0199	Subacute medical – high-cost IV drug*
0118, 0128, 0190, 0192	Subacute rehab
0206, 0193	Ventilator dependent-chronic care
0200, 0194	Ventilator dependent-active weaning

**High-cost IV drug is when the cost of the drug is greater than $100 AWP.*

Note: When billing for inpatient services that are reimbursed per diem, acute care hospitals and SNFs should bill the revenue code applicable to the bed level the patient occupies while hospitalized. If the bed level revenue code billed differs from what was authorized, we will reimburse according to the bed level billed, not to exceed the bed level revenue code authorized.

Managed care products

The facility’s per diem rate is all-inclusive for Members at a skilled or subacute level of care. Facilities are responsible for paying any subcontracted Provider who furnishes ancillary services to inpatient Members. This includes, but is not limited to, the following:

- routine diagnostic lab tests and processing
- venipuncture
- DME (except for those items set forth under the exceptions noted below)
- enteral feedings
- medical/surgical supplies
- parenteral hydration therapy
- pharmaceuticals, including IV therapies
- physical, occupational and/or speech therapy, including supplies to support these services
- routine radiology services performed onsite at the SNF

The services itemized below should be Preapproved/Precertified by an Independence-Participating Provider who will bill and be reimbursed directly for the service.

The following items are excluded under the per diem rates.

- DME:
  - customized orthotics/prosthetics
  - low air loss specialty beds/mattresses and Clinitron®/air fluidized beds consistent with CMS Group II and III requirements
  - bariatric beds
  - wound vac devices and supplies
- Other services:
  - Physician services
  - MRIs, CAT scans, Doppler studies
  - emergent transportation
  - dialysis services
  - blood and blood products

Referrals for HMO Members in long-term care/custodial-care nursing homes

A Referral is required for ancillary services or for consultation with a specialist for Members residing in long-term care (LTC) or nursing homes. In such cases, Preapproval/Precertification is not required. We have established LTC panels for our PCPs who provide care in LTC participating facilities. The LTC panels do not have designated ancillary services (e.g., laboratory, physical therapy, radiology, or podiatry). The completion of a Referral is required for any ancillary service for an LTC panel Member. In addition, a Referral is required for any specialist Physician consultation and/or follow-up for an LTC panel Member.

LTC panel PCPs must issue Referrals for any professional service or consultation for an LTC panel custodial nursing home Member. Examples of services that required Referrals include specialist, podiatry, physical therapy, and radiology. Participating Providers should submit Referrals in advance of the service being provided using PEAR PM.

Consultants and ancillary Participating Providers are encouraged to provide Referral information with the claim to assist in processing. Preapproval/Precertification is required only for inpatient admission for hospital care, SNF care, short procedure unit cases, or outpatient surgi-center procedures.

During an approved skilled nursing care admission, it is not necessary for the attending Physician to issue a Referral. All Participating Providers giving care to the Member should use our inpatient skilled nursing care authorization number for claims during dates of service within the skilled nursing inpatient stay.

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

Podiatry services for HMO Members only in SNFs

The HMO podiatric benefit is intended to cover services required to treat significant structural and/or inflammatory pathologic conditions of the foot — not to provide routine foot care to all Members. Routine foot care is a covered benefit only for Members with diabetes or peripheral vascular disease.

The SNF Preapproval/Precertification will allow claims to pay to any HMO network podiatrist who treats a Member receiving skilled or subacute care. If special circumstances require the

use of a podiatrist outside of the HMO network, the PCP must contact the Clinical Services – Utilization Management department for Preapproval/Precertification.

Part B therapy services

SNFs that provide outpatient physical, occupational, or speech therapy services will be reimbursed separately only for Medicare Advantage HMO and PPO Members who reside at the facility at a custodial level of care.