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Overview

The Billing section is designed to keep you and your office staff up to date on how to do business with us. Included are topics such as submitting Clean Claims, submitting proper codes used for accurate billing and disbursement, and information and requirements pertaining to your National Provider Identifier (NPI). In addition, this section contains important information about electronic transaction channels, including clearinghouse options for electronic claims submission and the Provider Engagement, Analytics & Reporting (PEAR) portal.

PEAR portal

The PEAR portal provides fast, secure web access to applications designed to help you manage your clinical and certain financial activities. In addition, it is a vehicle for you to obtain a variety of Plan information specific to your Provider organization as it relates to providing care for Independence Members.

For detailed information on the PEAR portal, see the *Administrative Procedures* section of this manual.

Correct coding principles

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:
  - Excludes 1 and Excludes 2 Notes
  - "Code Also" and "Code First" instructional notes
  - Laterality conflicts - diagnosis codes that specify laterality (right, left) require other code sets (e.g., modifiers) to match
  - 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: 26, 59, 77, 78, 79, 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 labeled indications and approved off-label indications
  - Reporting diagnosis codes in accordance to 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 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) by 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 in order 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.

Diagnosis Pointers

Diagnosis pointers are used to link a diagnosis code to the service being performed. Claim forms allow up to twelve diagnosis codes per claim. Although twelve diagnosis codes are allowed per claim, only four diagnosis codes are allowed per line item (each individual procedure code). When a service is billed the provider must connect or “point” the specific diagnosis that identifies the condition that the procedure was performed to treat, so at least one pointer per procedure code is required and the total number of diagnosis pointers per line are limited to four.

ICD-10 Excludes1 and Excludes2 guidelines

The Excludes1 and Excludes2 guidelines are applied in the claim editing process. According to the *ICD-10-CM Official Guidelines for Coding and Reporting*, there are two types of excludes notes, Excludes1 and Excludes2. Each type has a different definition for use, but they are both similar in that they indicate that codes excluded from each other are independent of each other.

Excludes1

Excludes1 is a pure excludes note. It means "NOT CODED HERE." An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 note is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

An exception to the Excludes1 definition is the circumstance when the two conditions are unrelated to each other. If it is not clear whether the two conditions involving an Excludes1 note are related or not, request clarification from the Provider. For example, code F45.8, Other somatoform disorders, has an Excludes1 note for "sleep related teeth grinding (G47.63)," because "teeth grinding" is an inclusion term under F45.8. Only one of these two codes should be assigned for teeth grinding. However, psychogenic dysmenorrhea is also an inclusion term under F45.8. A patient could have both this condition and sleep related teeth grinding. In this case, the two conditions are clearly unrelated to each other. It would be appropriate to report F45.8 and G47.63 together.

Excludes2

Excludes2 represents "NOT INCLUDED HERE." An Excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, when appropriate.

Clinical Relationship Logic

Clinical Relationship Logic pertains to the edits used to appropriately adjudicate claims in a claims processing system. Clinical Relationship Logic, or Code-to-Code Edits (e.g., Incidental, Integral, Component, Mutually Exclusive, etc.), is applied to claims submitted on the CMS-1500 claim form or through the 837P transaction. Medicare's National Correct Coding Initiative (NCCI) Edits are also applied.

This is not an all-inclusive list of claims editing that may be applied. Services continue to be subject to Independence claims adjudication logic, eligibility, benefits, limitations, exclusions, precertification/Referral requirements, Provider contracts, and Independence policies.

Visit *www.ibx.com/providers/claims_and_billing/clinical_relationship_logic.html* to access the code-to-code edit list and NCCI Edits.

Billing/reimbursement requirements

Providers are required by the HIPAA Transactions and Code Sets Rules to use only codes that are valid at the time a service is provided from the following coding systems:

- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)

National entities, including the American Medical Association, CMS, and the U.S. Department of Health and Human Services (HHS), release scheduled updates to CPT, HCPCS, and ICD-10-CM diagnosis codes, respectively. We monitor those schedules and react according to the following timeline:

- **CPT:** Biannual release of codes with effective dates of January 1 and July 1.
- **HCPCS:** Quarterly release of codes with effective dates of January 1, April 1, July 1, and October 1.
- **ICD-10-CM:** Annual release of codes with effective date of October 1.

Note: Timeline reflects schedule of the dictating entity and, therefore, may be subject to change.

Providers are required to bill Usual, Customary, and Reasonable charges for codes that are valid at the time of service.

CPT and HCPCS billing codes

Services must be billed using the appropriate five-digit numeric or alpha-numeric CPT or HCPCS procedure code. Attachments or written descriptions of the services being performed will not be considered a proper billing procedure. Documentation in the Member's medical record must clearly support the procedures, services, and supplies coded on the health insurance form.

Note: Some CPT codes may be included in global fees to facilities and therefore are not eligible for separate reimbursement. You may bill the facility in those instances.

Services or procedures should be reported with the specific CPT or HCPCS when available. If a specific CPT or HCPCS code cannot be located, an unlisted code may be reported. Unlisted procedure codes *should not be used* unless a more specific code is not available.

Unlisted procedure codes

Each section of the CPT coding system includes codes for reporting unlisted procedures. They may be new procedures that have not yet been assigned a CPT code, or they may simply be a variation of a procedure that precludes using the existing CPT code. Because unlisted procedure codes are subject to manual medical review, processing may take longer than usual.

All unlisted/not otherwise classified (NOC) codes must be submitted with the appropriate narrative description of the actual services rendered on the CMS-1500 claim form in order to be processed. For claims that are electronically submitted, refer to the *HIPAA Transaction Standard Companion Guide* available at *www.ibx.com/edi*.

- **Paper.** For paper-submitted claims, additional information regarding the narrative description of the specific services provided should be submitted on the CMS-1500 claim form in the shaded area extending from field 24A through 24G, directly above the NOC/unlisted procedure code. If a description is not provided, the entire claim will be rejected with a message to resubmit with a narrative description.
- **Electronic.** For electronically-submitted 837P claims, the NOC descriptions should be filled into the Loop 2400 data element SV101-1 – Description.

Pricing procedure for unlisted or NOC services

This pricing and processing procedure for unlisted or NOC Covered Services is used for all products covered under your Professional Provider Agreement (Agreement).

- We maintain a database of historical pricing decisions for similar services previously reviewed and priced by Independence. If available, an appropriate fee in this database may be used to price the current claim.
- If the database does not have pricing for the current claim, then the claim is reviewed by Independence for a pricing decision. We may request that the Provider submits additional information to facilitate pricing the claim. The additional information requested may include, but is not limited to, an operative report, a letter of Medical Necessity, an office note, and/or an actual manufacturer's invoice. Providers should submit additional information only if specifically requested to do so by Independence. Upon being recommended for payment and processing, claims are priced using our standard pricing methodology, which is designed to consider new procedures, and are processed in accordance with applicable claim payment policies and exclusions and limitations in benefits contracts.
- Providers who disagree with a specific unlisted/NOC service pricing determination should follow the normal process for billing disputes as described in the *Appeals* section of this manual.

Providers are reminded to always use the most appropriate codes when submitting claims. Claims submitted with NOC codes when a valid CPT or HCPCS code exists may be denied.

National Drug Code submissions

Pharmacy and medical claims for all unlisted and nonspecific drug codes (without a corollary CPT or HCPCS code) require submission of a National Drug Code (NDC) in the correct format and location to properly adjudicate these claims consistent with our group benefits plans. If any NDC billed is not submitted in an 11-digit format, cannot be validated, or is missing when required, the claim will not be processed and will be returned to you for correction. The 11-digit format is 5-4-2 and is found on most drug packaging. This format serves a functional purpose: The first segment of the NDC identifies the labeler/manufacturer; the second segment identifies the product, strength, dosage form, and formulation; and the third segment identifies the package size of the drug.

Note: Compound drugs should be reported with (1) an unlisted and/or nonspecific (CPT or HCPCS) code and (2) the NDC with the most expensive ingredient.

The FDA guidelines for NDC submission for co-packaged products listed as kits and multi-level packaged products are as follows:

- For co-packaged products listed as kits and multi-level packaged products, providers should report the NDC on the outermost package. Only the outermost NDC is reported by firms as part of their product listing submission to the FDA and included in the NDC directory. Only NDCs included in the NDC directory will be considered valid NDCs for claims submission.

Report diagnosis codes to the highest degree of specificity

We require that all Providers report diagnosis codes to the highest degree of specificity according to the most current ICD-10-CM. This requirement applies to all claims and encounters. It reflects:

- the need for better diagnostic information for quality and medical management;
- the decision to make our coding policy more consistent with other major carriers and with CMS ICD-10 coding guidelines;

- the decision by CMS to determine Medicare Advantage premiums based on the severity of illness of enrolled Members. Supporting documentation in the Member's medical record must clearly support the procedures, services, and supplies coded on the claim form.

Always report with the highest level of specificity possible for an individual patient.

HIPAA 5010 and ICD-10

- **HIPAA 5010.** 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. The HIPAA Transaction Standard Companion Guide is available at *www.ibx.com/edi* to assist you in submitting HIPAA 5010-compliant transactions.
- **ICD-10.** HHS requires the use of ICD-10-CM on all claims. Visit *www.cms.gov/icd10* for more information.

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. 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

Included in this section is billing information specific to certain types of services, including diagnostic ultrasounds, interrupted maternity care, observation services, office-based services, radiologic guidance, routine gynecological exams, and surgery claims.

Diagnostic ultrasounds

Certain participating specialist types are eligible to provide specific diagnostic ultrasounds to HMO and PPO Members. HMO Members do not require a Referral from their Primary Care Physician (PCP) for diagnostic ultrasound services provided by the OB/GYN specialists.

Note: Although certain participating specialist types are eligible to provide specific diagnostic ultrasounds, in some Service Areas, we have an arrangement in which we pay the hospital a global payment when the service is provided in the outpatient hospital. In these instances, the Provider EOB will indicate that the Provider must seek reimbursement from the hospital.

Outpatient hospital

Additionally, for HMO Members, hospitals that are not the Member's capitated radiology site may perform and be reimbursed for specific diagnostic ultrasounds. If the hospital is the capitated radiology site for the Member, these Covered Services are included in the capitation payment and no additional payment will be made.

For more detailed information, including the eligible procedure and diagnosis codes, please refer to our policies on obstetrical ultrasounds at *www.ibx.com/medpolicy*.

Interrupted maternity care

If you provide prenatal visits alone to any Independence Member, bill those services with the appropriate CPT code as follows:

- **Fewer than four visits.** If you provided fewer than four visits total, bill visits one through three with the appropriate evaluation and management (E&M) code, based on the history, exam, and medical decision-making documented in the record. Bill one E&M code for each visit.
- **Four to six visits.** If you provided a total of four to six visits, bill *only 59425*.
- **Seven or more visits.** If you provided a total of seven or more visits, bill *only 59426*.

Long-term care facility services

Services for Members in a long-term care (LTC) facility are to be billed with Place of Service code 32. Taxonomy code 311Z00000X should be used by Providers to identify that they are billing for their LTC panel. PCP LTC panels are reimbursed on a fee-for-service basis.

Failure to submit claims for services performed in the office or LTC facility with the applicable NPI and correct correlating taxonomy code may result in incorrect claims processing.

Multiple services

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.”

The only instances when split-billing is acceptable to Independence are when we specifically require services to be billed on separate claims based on an Independence policy (i.e., assistant or co-surgery claims). Some examples of split-billing, which is not allowed by Independence, include:

- two or more procedures or services performed by the same Provider, on the same date of service, on the same patient, and submitted on more than one claim form;
- services considered included in the primary services and procedures as part of the expected services for the codes are billed on separate claim forms.

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 over-stated.

If a service for which there is no policy to support split-billing is inadvertently omitted from a previously submitted claim, the original claim should be corrected and resubmitted. Do not submit a separate claim for the omitted services, as that will create a split-billed claim and all individually submitted claims will be adjusted to deny.

Observation services

When an attending Physician provides service to a Member at an observation level of care, the Physician should use the following Evaluation and Management (E&M) codes when billing for these services to ensure accurate processing of the claim:

- 99217
- 99218
- 99219
- 99220
- 99234
- 99235
- 99236

We recognize the appropriate use of observation services (i.e., observation status and observation level) to monitor patients and treat medical conditions on an outpatient basis and to evaluate a patient's need for acute inpatient admission. Observation services are outpatient services that include diagnosis, treatment, and stabilization of patients from a minimum of eight to a maximum of 24 hours, per InterQual® guidelines.*

Independence's policies for facility reporting of observation services supersede InterQual guidelines. In this instance, Independence's policies stating the treatment and/or procedures must* ***include at least eight hours of observation supersedes the InterQual standard of six hours.* *For more information on these policies, visit our Medical Policy Portal at www.ibx.com/medpolicy.*

Independence uses guidelines for decision-making from InterQual, a product of Change Healthcare, an independent company, to determine which patients have severity of illness and intensity of service requirements that are appropriate for observation. Observation services can be provided in any location within a facility.

Office-based services

If an office-based service (e.g., an office visit or outpatient consultation) is performed by a professional Provider in an office-based setting within a facility or on a facility campus, the facility is not eligible for reimbursement and should not bill for the service. Only the professional Provider is eligible for reimbursement for the service provided to the Member.

The facility is not eligible to receive reimbursement for a room charge even though a professional Provider office may be located within the facility.

Pass-through billing

Independence does *not* allow pass-through billing for Covered Services. In accordance with your Agreement, you may bill Independence only for Covered Services that you or your staff perform. Participating Providers are not permitted to submit claims for services that they have ordered, but they have not rendered (also known as "pass-through" billing). For example, pass-through billing by a Physician practice of laboratory services performed by a third-party laboratory is not reimbursable by Independence.

You should use an Independence-contracted laboratory to perform pathology services for Independence Members, including both the technical portion and the professional portion of the services. The laboratory should bill Independence directly for services it performs – they should not attempt to bill your practice for services.

Note: Claims submitted for pathology services that are billed by an office-based pathologist will be denied. However, dermatologists who perform certain pathological procedures in their office (at the time of a patient's visit) may bill Independence for the service.

Radiologic guidance of a procedure

The following reimbursement methodologies apply to claims processing of radiologic guidance and/or supervision and interpretation of a procedure:

- Radiologic guidance and/or supervision and interpretation of a procedure are performed by either the same professional Provider who performs the surgical procedure or a different professional Provider.
- Radiologic guidance and/or supervision and interpretation of a procedure are performed in conjunction with a Covered procedure and are eligible for separate reimbursement consideration by Independence.

When the same Provider performs and reports both the radiologic and the diagnostic or therapeutic procedures, both procedures are eligible for reimbursement consideration to the Provider. However, both of the following requirements must be met:

- Both the radiologic guidance and/or supervision and interpretation service — as well as the procedure for which it is performed — must be covered for the radiologic guidance and/or supervision and interpretation to be eligible for separate reimbursement consideration.
- Documentation in the medical record must reflect the radiologic guidance and/or supervision and interpretation procedure performed by the Physician. The medical record must be available to us upon request. Providers should not submit medical records to us unless otherwise requested. Visit *www.ibx.com/medpolicy* for more information about our claim payment policy for radiologic guidance of a procedure.

Routine gynecological exams

Visit *www.ibx.com/medpolicy* for more information about our policy on female preventive care services, including routine gynecological exams.

For additional information, refer to the *OB/GYN* section of this manual.

Services eligible for reimbursement above the capitation rate

Most Medically Necessary and preventive services provided to our commercial and Medicare Advantage HMO and POS Members by a PCP are included in the monthly capitation payment. However, some services that can be performed at a PCP's office (e.g., wart removal or vaccines) are eligible to be paid above the monthly capitation rate.

A complete list of services that are paid over and above the monthly capitation payments (above capitation) is available in Attachments A, B, and C (depending on PCP's state) in the appropriate Independence policies.

PCPs are also eligible to receive payment above capitation for codes listed in the injectable drug and vaccine fee schedules. If you opt to perform these services in your office, be sure to submit the required documentation as noted in the policy. By using these fee-for-service reimbursements, we can help our Members by reducing the need for Referrals or specialist visits.

Visit *www.ibx.com/medpolicy* for more information about our policy for services eligible for reimbursement above the capitation rate.

Surgery claims

Providers are required to follow the appropriate billing procedures as they relate to multiple surgeries, assistant surgery, and co-surgery.

Multiple surgeries

- **Performed on the same date of service.** Surgeons must bill multiple surgical procedures for the same date of service on a single claim.
- **Performed on different dates of service.** To avoid claim underpayments, surgeons must bill multiple surgical procedures for different dates of service as separate claims.

Assistant and co-surgery

For surgical procedures performed by both a primary surgeon and an assistant surgeon or co-surgeon, separate claim submissions are required. The primary surgeon and assistant surgeon or co-surgeon must report separate claims.

- **Performed on same date of service.** Multiple surgical procedures performed on the same date of service must be reported on a single claim (i.e., one claim for each surgeon).
- **Performed on different dates of service.** To the extent that a surgeon, assistant surgeon, or co-surgeon performs multiple surgical procedures on different dates of service, each date of service must be reported on its own claim.

Inappropriate billing may result in erroneous claim payments. For more information regarding assistant surgery, co-surgery, and multiple surgery guidelines, review the respective claim payment policies, which are available at *www.ibx.com/medpolicy*.

Taxonomy codes

Independence requires the use of taxonomy codes to ensure proper claims processing. If a Provider group NPI is associated with more than one Independence specialty, the Provider must include the appropriate Provider taxonomy code in addition to the NPI on all claims. Failure to submit claims with the applicable NPI and correct correlating taxonomy code may result in incorrect claims processing and/or payment delays.

Clean Claims

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

Incomplete and inaccurate claims will be returned as non-clean claims. Returned claims are not necessarily a denial of benefits but arise from our need for accurate and complete information. Additionally, claims that do not have adequate information to identify the billing Provider can be neither processed nor returned.

Clean Claims (both electronic and paper-submitted) must meet the following conditions:

- The service is a Covered Service by the Independence Member's benefits plan.
- The claim is submitted with all required information on a claim form or in other instructions distributed to the Provider.
- The person to whom the service was provided was an Independence Member on the date of service.
- We do not reasonably believe the claim was submitted fraudulently.
- The claim does not require special treatment. Special treatment means unusual claim processing is required to determine whether the service is covered.

Clean Claims requirements

The following information must appear correctly for a claim to be considered clean:

- Group Provider NPI*
- performing Provider NPI
- tax ID number
- address of the group's practice location
- Patient's ID number (including applicable prefix)
- Patient's date of birth
- Name of the patient receiving services

**Be sure the Group Provider NPI is associated with the Group Tax ID number on file at Independence.*

Provider NPI requirement

For purposes of processing a claim, you must submit a valid NPI as the primary identifier on the claim. In addition, the performing Provider NPI must be recorded on all claims. This is a required data element in conjunction with HIPAA compliance and other requirements. HMO, POS, and PPO claims submitted without the NPI of the Physician or other professional Provider performing the procedure or service will be rejected and returned as non-clean claims, which must be resubmitted with the necessary information.

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 reject.

Note: Taxonomy codes are used to distinguish Provider specialties and are required on all claims.

Further information about NPIs and how to bill using NPIs is available on our website at *www.ibx.com/npi*.

Member ID numbers on ID cards

To better protect Member identity and privacy, we use a unique Member ID number for external communications to Members, including on all Member ID cards. Use this Member ID number when processing Member information. Please note the following for Independence Members:

- Members have a 3-character prefix and a 12-digit Member ID number, called a "unique Member ID" (UMI).
- The subscriber and all Members covered under the subscriber's policy share the same ID number.
- Members with our Medicare Supplement plan – MedigapSecurity – have a 13-digit ID number, with the last digit being an alpha character.

For all local and out-of-area claims, always include both the prefix and complete Member ID number as it appears on the Member's ID card to facilitate claims processing. Independence rejects claims not billed with the complete Member ID number and date of birth. For timely and accurate claim payment, the full Member ID must be billed as it appears on the Member ID card.

Note: For HMO and POS Members, the laboratory indicator (e.g., A, H, L, M, N, or T) located on the front of HMO and POS Member ID cards should not be included in the Member's ID number.

Place-of-service codes

Participating Providers are required to use the most current place-of-service codes on professional claims to specify the entity where service(s) was rendered. The most frequently submitted place-of-service codes are listed in the following table. Always consult with your vendor or practice management system contact to discuss payer-specific changes to your system.

Place-of-service code	Place-of-service name
11	Office
12	Home
21	Inpatient
22	Outpatient
23	Emergency department/room — hospital
Place-of-service code	**Place-of-service name**
24	Ambulatory surgical center
31	Skilled nursing facility
32	Nursing facility
41	Ambulance — land
42	Ambulance — air or water
65	End-stage renal disease treatment facility
81	Independent lab

Submitting claims

Visit our website at *www.ibx.com/edi* for information on claims submission, 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, the *HIPAA Transaction Standard Companion Guide*, payer ID grids, claim form requirements, and the Trading Partner Business Center.

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).

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

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 his or her 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.

CMS-1500 claim submitters

All paper claims must be submitted on a CMS-1500 claim form. A sample CMS-1500 claim form is included in the CMS-1500 claims submission toolkit, available at *www.ibx.com/providers/claims_and_billing/claims_resources_guides.html*.

Providers who submit CMS-1500 claim forms can also submit these claims by using the 1500 Claim Submission transaction on PEAR PM. Providers are then able to review the status of these submitted claims through the Claim Log transaction. Please keep in mind the following when using the 1500 Claim Submission transaction:

- Claims submitted using this transaction must have a date of service on or after October 1, 2015.
- Providers are able to use the 1500 Claim Submission transaction to submit Independence commercial and Medicare Advantage claims, as well as out-of-area Medicare Advantage PPO claims.
- Providers are not able to use the 1500 Claim Submission transaction to submit claims with secondary and tertiary payers.

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

Electronic claim submitters

To process EDI transactions, Independence uses the Highmark Gateway, which is managed and operated by Highmark, Inc.

If you submit claims electronically, you will receive a 277CA for notification of both rejected and accepted claims. The error description on the 277CA will aid you in correcting and resending claims to ensure an expedited remittance.

For more information about claims resolution, refer to the professional Claims Resolution Matrix, available on the Independence Trading Partner Business Center at *www.highmark.com/edi-ibc* under Resources.

For questions related to conducting EDI business with Independence via the Highmark Gateway, please call Highmark EDI Operations at 1-800-992-0246. Highmark EDI Operations is available Monday through Friday, 8 a.m. to 5 p.m., ET.

Clearinghouse options for electronic claims submission

Your software vendor may be contractually obligated to use a specific third-party clearinghouse vendor for electronic submissions. That clearinghouse can assist you with testing to ensure that your electronic claims submissions are seamless. Many clearinghouse options are available.

Clearinghouses may update their submission rules from time to time. Always contact your clearinghouse for confirmation of up-to-date, specific submission requirements.

If you are interested in submitting electronic claims and have existing practice management software, contact your vendor as they will more than likely have an existing clearinghouse vendor that connects to the Highmark Gateway.

Submitting Coordination of Benefits information electronically

Providers may submit Coordination of Benefits (COB) information electronically for professional services using the 837P format. For instructions on how to bill electronically, visit *www.ibx.com/edi*.

Submitting COB information electronically eliminates the need for paper claims submission. Claims submitted electronically are processed faster and have a significantly higher "first-pass" adjudication rate. This means faster payment to you.

Medicare crossover process

Per the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross® and Blue Shield® plans, Providers should submit all Medicare crossover adjustment requests and all 100 percent Medicare-denied claims (where there is additional Beneficiary liability) electronically through Group Health Incorporated.

Through the BCBSA's national Medicare Advantage PPO Network Sharing Program, we accept Medicare Advantage PPO enrollees from other Blue plans who travel or reside in our five-county Philadelphia service area as our local Members. Claims for these Members should be submitted to Independence for processing.

Claims resolution

We have published claims resolution documents that highlight rules that are applied to claims and advise on how to remedy rejected claims for resubmission of a Clean Claim. These documents are available on the Trading Partner Business Center at *www.highmark.com/edi-ibc* under Resources.

Please note that Providers should continue to submit claims according to our guidelines. Provider claims will continue to be validated against the existing business rules.

Submission of claims adjustments

When submitting adjustment requests electronically to Provider Network Services using Microsoft® files (e.g., Excel® or Access®), please submit the following fields:

- Independence claim ID number
- Member ID number
- date of service from/to
- procedure/service code
- Member first and last name
- Subscriber ID number
- vendor (billing) Provider name and number
- performing Provider name and number
- modifier
- modifier
- modifier
- revenue code
- units billed
- charged (billed) amount
- allowed amount
- payment amount
- expected amount

By submitting your adjustment requests with the fields listed, we will be able to improve the turnaround time and maintain a higher level of service while processing the claim.

Provider Claims Inquiry

Participating Providers are required to use the Claim Search transaction on PEAR PM to submit claim investigations including requests for claim review for claims that have been finalized by the health plan.

Providers can then view responses to their questions using the Claim Investigation Search transaction. The Provider claims review process will consider HMO, POS, and PPO claims payment issues concerning the application and correction of coding, claims logic, and other general issues related to claims processing norms. Claims data is available in our system for up to 18 months prior to the current date. *Note:* Providers can continue to submit corrected claims electronically or manually through paper.

Please note the following:

- Ensure that you have access to the portal and understand how to utilize the transaction.
- We will continue to redirect those Providers who submit paper claim review requests to the portal to initiate the claim review.
- Please be specific when describing the reason for the claim review. *Note:* A number of Providers are submitting claim review requests for lack of Referral or authorization. If a claim denied for lack of Referral or authorization and one was required, you must submit a valid Referral or authorization number in order for the claim to be reconsidered.
- You ***cannot*** edit the claim or submit late charges – it must be submitted as a corrected claim.

If you have a large volume of claim review requests to submit for the same issue, please contact Provider Network Services to discuss *before* submitting multiple claim review requests through the portal.

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

Corrected claims

Claim edits and claim corrections are ***not*** permitted to be submitted through the claim investigation option on PEAR PM. If you need to edit a claim, a corrected claim must be submitted with the new information, and you need to note the original claim number on the corrected claim.

The term “corrected claim” is meant for corrections to claims that were processed and finalized in the adjudication system and for which a claim number was assigned, but the Provider wishes to have the following performed on the original claim:

- replacement of prior claim (correction of the charges/services originally submitted by the Provider);
- void/cancellation of prior claim (reflecting the elimination of a previous claim in its entirety);
- addition of late charges to an inpatient claim after the original claim was processed.

The corrected claim must be submitted under the same NPI as the original claim. If a claim was originally submitted under the wrong NPI, you must then submit a void request for the original claim number. Once the claim has been voided, you can submit a new claim under the correct NPI.

A common billing error is to resubmit an original claim type versus following corrected claim submission instructions. If more than one original claim type is received for the same encounter, it may be denied as a duplicate with reference to rebill as a corrected versus original claim submission.

Provider Explanation of Benefits (EOB)

The Provider EOB contains detailed claims information for the payment of claims, claims adjustments, and claims interest payments to Providers. Provider EOBs include A/R detail, when appropriate, and may contain multiple PDF documents. The various payment types include spending account payment, remittance payment, and facility remittance.

Participating Providers can use the EOB & Remittance transaction on PEAR PM to get claim payment information for finalized claims. Through this transaction, Providers can download and/or print their Provider EOB. Providers can also search for statements in two-week increments. Up to four months of historical remittance data will be stored at a time, so it is important to download and save reports on a regular basis.

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

Overpayments

If your office receives an overpayment from Independence* and you need to submit an adjustment to correct the overpayment, you can do so in one of the following ways:

- **PEAR PM.** Participating Providers should initiate an adjustment to correct an overpayment using the Claim Search transaction. From there you can enter one of the two appropriate search criteria options:
  - Billing Provider/Member ID/Date of Birth
  - Billing Provider/Member Last Name/First Name/Date of Birth

  You can submit the credit and/or retraction request through *Claim Investigation Submission*, which will appear on a future Provider EOB.
- **Overpayment/Refund Form.** Offices that are not yet PEAR-enabled can submit their adjustment request using the Overpayment/Refund Form, which is located at *www.ibx.com/providerforms*. Once the form has been completed, please mail it, along with a copy of the Provider EOB, to:

  Independence Claims Overpayment
  1901 Market Street, 39th Floor
  Treasury Services – Misc. Cash Receipts
  Philadelphia, PA 19103-1480

**Checks issued to providers apply for all types of spending in accounts. In all cases, the payment should be treated as a member-directed payment, so that any overpayment is directed back to the member.*

Explanation of Payment

Health Savings Account (HSA), Health Reimbursement Account (HRA), or Flexible Spending Account (FSA) funds will only be issued with a physical check. Spending account payments will ***not*** be made via electronic funds transfer. The physical check will be sent along with an Explanation of Payment (EOP).

Providers will be able to view HRA details through the Eligibility & Benefits transaction on PEAR PM, including the Deductible amount. Unless informed by the Member, Providers are unable to determine whether a Member has an FSA or HSA.

For medical claims that require processing to determine the Member liability, the claim is processed and then automatically sent to the spending account system to determine if the claim is covered and if funds are available under one or more spending accounts. Providers will be able to view EOPs through the EOB & Remittance transaction on PEAR PM. A spending account payment related to a medical claim will generally arrive a week after the claim has been completely processed.