BlueCross BlueShield of Nebraska

APRIL 2009

update

bcbsne.com

PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

High Deductible Health Plans

As consumers and employers seek to control health care plan costs, they are making the move toward purchasing high deductible health plans (HDHP). United States Treasury laws govern the requirements for a HDHP, including minimum deductibles and out-of-pocket maximums.

Blue Cross and Blue Shield of Nebraska offers HDHPs under both group and individual coverage. These plans generally don't pay for the first several thousand dollars of healthcare expenses. The plan may provide first dollar coverage for preventive care to encourage employees to seek preventive and wellness care.

Members enrolled in an HDHP may establish and fund a health savings account (HSA). An HSA is a tax-exempt trust or custodial account established for an individual to pay for health expenses and save for future qualified health expenses on a tax-free basis. In addition, the HSA :

- allows funding flexibility. Both employees and employers can contribute pre-tax dollars to the account. HSA dollars can be used for a wider range of health-related expenses that are not typically covered by other health accounts, such as purchasing long term care insurance.
- allows balances to rollover from year to year. This enables consumers to build up money in their accounts when they have low health care needs, leaving them with more money to cover out-of-pocket expenditures when the need arises.
- is portable. Workers who move from job to job take the account with them. The account is owned by the individual.

Correction — MedicareBlue PPO Vision Benefits

In the February 2009 "Update," we published an article titled "MedicareBlue PPO Vision Benefits."

The article's intent was to provide information on the "add-on" benefit for routine eye exams not offered by traditional Medicare—one routine eye exam per calendar year. The article included ICD-9 and HCPCS codes that could be billed for this benefit.

BCBSNE's Health Network Services would like to clarify that we will not mandate billing and coding—you should always bill according to the patient's condition and services rendered. The codes were provided as basic guidelines and not intended as exclusive coding for the routine benefit.

Under this routine eye exam benefit, MedicareBlue PPO will reimburse for the determination of refractive state at 60% of billed charges. This rate was set as a percentage because traditional Medicare does not have an allowance for this procedure. Additional covered services include lens tints and anti-reflective coating. Non-covered items include deluxe frames, scratch resistant coating, mirror coating and polarization.

The MedicareBlue PPO coverage for vision services includes a $35 copay for up to one routine eye exam every year for in-network providers. Additional information regarding vision coverage for MedicareBlue PPO members can be found at www.yourmedicaresolutions.com.

If you have questions about billing vision benefits for MedicareBlue PPO members, please contact your Health Network Consultant.

The Update is a bimonthly provider newsletter that contains up-to-date information about Blue Cross and Blue Shield of Nebraska (BCBSNE) for health care providers. It is published by the Health Network Management Services Department (HNS).

If you are a contracting BCBSNE health care provider, this newsletter serves as an amendment to your agreement and affects your contractual relationship with us. You are encouraged to file every issue of the Update within your BCBSNE Policies and Procedures manual and reference it often. You may also view the current manual in the Provider section at bcbsne.com.

As a service for Blue Cross and Blue Shield members, we also send this newsletter to non-participating Nebraska providers.

We also publish each issue online in the Provider section at:

bcbsne.com

For permission to reprint material published in the Update, e-mail the editor, Kimberly Bryant, at:

kimberly.bryant@bcbsne.com

The BlueBoard

Clarification - Roller Aid Billing

In the February 2009 "Update," we provided instructions on submitting claims for roller aid. Please note that roller aid is non-covered for BCBSNE member contracts. When submitting roller aid claims, include E1399 with a description of "roller aid" and attach the cost invoice. Roller aid is also known as a "knee walker," "knee bop," "knee drive", or "willy walker."

FEP Claims Submissions

The Federal Employee Health Plan (FEP) requires that all medical claims be submitted to the local Blue Cross and/or Blue Shield Plan where the services were provided. If an FEP member receives care in a state other than where he or she resides, the claim must be submitted to the local Blue Cross Blue and/or Shield Plan where the services were provided. FEP members can be recognized by their ID number, which begins with "R" on the ID card.

The Importance of Box 10 on CMS 1500 Form

To ensure claims are processed accurately and in a timely manner, the following questions must be answered in Box 10 on the CMS 1500 form. These questions must be answered by the member on every visit:

Is the patient's condition related to:

Employment Yes or No
Auto Accident Yes or No
(If answering yes, please include state where accident happened)
Other Accident Yes or No

If Box 10 is not accurately completed on every visit, claim processing may be delayed or denied.

Billing for Vaccine Administration

When filing a claim for immunizations, be sure to bill the proper administration code(s) along with your charge(s) for the vaccine/toxoid. As noted in the 2009 CPT Coding Book, Professional Edition, the administration codes that must be reported in addition to the vaccine and toxoid code(s) are within the CPT code range 90465-90474. Do not use 96372-96379 when billing for the administration of a vaccine or toxoid. These codes are to be used for therapeutic or diagnostic injections only. Using an incorrect code will result in denial of the submitted claim.

Before You Submit, Check the Card

ID numbers are critical to accurate claim processing. Always check the member's card upon each office visit. Never change an alpha prefix without seeing the card.

Important note: Please discontinue including the two-digit suffix on the end of BCBSNE member IDs when filing claims.

BlueCard® Bulletin

Claim Filing Tips for Contiguous County Providers

The standard rule for submitting claims for BlueCard eligible members is to file the claim to your local Blue Cross and Blue Shield Plan for processing. The member's Blue Plan advises the local Blue Plan if the services billed are payable according to the member's coverage. Payable services are then priced according to the contract the provider has with the local Blue Plan. If the provider also holds a contract with a Blue Plan in a bordering state, this changes the process.

Some Blue Plans have provider networks that extend into contiguous counties of bordering state(s). Generally, these networks are applicable to specific products, e.g., HMO networks. What this means is:

- If the provider has a contract with the Blue Plan in the neighboring state, and;
- The patient is an insured of the Blue Plan and the provider participates in that specific Plan's network, then;
- The provider should file the claim directly to the bordering Blue Plan – NOT the local Blue Plan.

If you hold a contract with a Blue Plan in a bordering state, you should have information from that Plan regarding applicable network(s) with which you participate, as well as instructions on how to identify their members. If you are unsure, you should contact the Provider Relations Department of the bordering Blue Plan to verify this information.

In the event the claim is inadvertently submitted to the local Blue Plan, it will be denied with Remark Code 1H1, which states, "Provider contracts with Plan in which the member is insured. Please submit claim to that Plan for processing."

Submitting the claim directly to the correct Blue Plan for processing will prevent unnecessary delays in receiving payment for covered services.

Electronic Claim Edit Mandates for April

The Centers for Medicare and Medicaid Services (CMS) has issued the following mandates for April:

1. A full 9-digit zip code must be used for billing, performing and servicing facility provider zip codes when the 5-digit zip code spans more than one CMS pricing area. Currently, institutional and professional Medicare Advantage claims are priced using 5-digit zip codes.
2. A new edit has been added to ensure the service facility zip code is populated for ambulance services for Medicare Advantage. CMS requires ambulance service claims to have a ZIP code for where the ambulance picks up the patient to calculate mileage.

Because of these CMS mandates, new edits will go into production on April 19, 2009 for **Electronic Medicare Advantage claims only**. Details on these edits can be found in our BCBSNE companion guides located under the Library section of our NEBLUEconnect page: **bcbsne.com/Providers/NEBLUEConnect**

Save money and time with electronic posting.
Save natural resources by reducing the use of paper and fossil fuels used to transport paper remits.
What are the benefits of using electronic remits and funds transfers?

Go Green With BLUE

- Electronic remits are easier to sort, view, and retrieve than paper remits.
- Electronic funds transfers are automatically deposited and never get lost or delayed in the mail.

Providers have two options for receiving electronic remittance advices:
- Download directly from BCBSNE
- Receive remits from your clearinghouse

To begin receiving electronic remittance advices and electronic funds transfer, fill out and fax us the form, located at the following link: bcbsne.com/providers/forms.
Please feel free to contact Howard Jones or Sean Blair with your questions:

Howard Jones
North of I-80 and Lincoln
402-343-3301
howard.jones@bcbsne.com

Sean Blair
South of I-80 and Omaha
402-392-4205
sean.blair@bcbsne.com

When you talk to Howard or Sean, don't forget to ask about our free software for viewing and sorting BCBSNE electronic remittance advices. Sign up today!

Tips for Efficient TriCare Claims Processing

Providers can take simple steps to expedite the processing of their TRICARE West Region claims, reduce the time spent on tracking the status of submitted claims and eliminate the need to submit duplicate or tracer claims.

Take advantage of the newest enhancements on the TriWest secure provider Web site, triwest.com/provider. As a registered provider, you can perform a variety of self-service functions:

- Verify patient eligibility
- View your patient panel report (primary care managers only)
- Determine the status of referrals and authorizations
- Submit, view and check claim status
- Download Explanations of Benefits forms
- See which payments have been issued

As a registered user, you can submit your professional and institutional claims online and receive real-time processing results. Currently, clean claims (e.g., those that do not contain a defect requiring investigation or development before adjudication) submitted online are being processed within the following time frames:

- 71 percent immediately
- 97 percent in 15 days or less
- 99.7 percent in 30 days or less

Second submissions and tracer claims can delay claims processing, influence the accuracy of claims payment and cost your practice valuable time. You can help avoid these problems by allowing at least 45 days from the date the claim is received at Wisconsin Physicians Service (WPS) before generating second submissions or tracers. This allows WPS time to receive the claim from your office or billing service and process all clean claims, as well as time for the U.S. Postal Service to deliver your payment and your office to post it.

Mark Your Calendars for Upcoming TriWest Seminars

Behavioral Health

Omaha - May 7, 2009
1:30 – 4 p.m.
Crowne Plaza Omaha – Old Mill
655 N. 108th Ave.

Medical/Surgical

Omaha – May 7, 2009
9 – 11:30 a.m.
Crowne Plaza Omaha
Old Mill
655 North 108th Ave.

Omaha – May 14, 2009
9 – 11:30 a.m.
DoubleTree Guest Suites-Omaha
7270 Cedar St.

1:30 – 4 p.m.
DoubleTree Guest Suites-Omaha
7270 Cedar St.

Register online at triwest.com/provider or call 888-874-9378 or e-mail providerservices@triwest.com with any questions.

Inside update

Highlights from Recent Issues Online:

Click on the green Provider tab at www.bcbsne.com, then Library and then Newsletters for current and archived newsletters.

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Electronic Claims Require NPI Numbers!
August 2008

Timely Filing is Your Responsibility
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