PARTNERING WITH YOU FOR A HEALTHIER NEBRASKA

The Importance of the National Provider Identifier

To expedite claim processing and minimize errors, please adhere to the guidelines noted below when filing CMS 1500 claim forms to BCBSNE:

- **Type 1 (rendering provider)** – the NPI must be in box 24J and must coincide with the provider file information in box 31.
- **Type 2 (organizational)** – the NPI must always be in box 33A.

Note to Ambulatory Surgery Centers and Durable Medical Equipment providers: You should always report your Type 2 NPI in box 24J. Never report the surgeon or ordering MD’s individual NPI in box 24J.

**Paper Claims Guidelines**

- Box 24J must include the Type 1 (rendering provider’s NPI)
- Box 31 must include the last name, first name and credentials of the rendering provider. Do not use any punctuation.

  **Example:**
  Doe John MD

- Box 33A must include the entity’s NPI number in box 33A.

**Electronic Claim Guidelines**

- The 2310B Loop (rendering) should include the last name, first name and individual NPI
- The 2010AA Loop (billing) should include the billing entity’s name and organizational NPI

If you have not obtained an NPI, you will need to obtain one and advise BCBSNE of the NPI for claim filing. NPI notification forms are located on the Provider page at bcbsne.com, under “Forms.”

In addition to needing individual NPIs, we need the date of birth and social security number of the provider. Once we have received this information, we will update our provider files.

*See additional information regarding the importance of Box 32 on the CMS 1500 on page 6.*
Anticoagulation Management Codes
Effective for dates of service January 1, 2010 and after, anticoagulation management codes 99363 and 99364 are now payable (when billed alone, not with evaluation and management) on our Legacy claims processing system.

Dental Anesthesia Services Billing
Dental anesthesia services should always be billed with D9220 or D9221 and should always be billed with units, not minutes.

**D9220** – Deep sedation/general anesthesia – the first 30 minutes should always be a unit of one.

**D9221** – Deep sedation/general anesthesia – each additional 15 minutes should always include the number of units that the anesthesia was administered. Note that one unit equals 15 minutes of time. For example, total anesthesia time equates to 45 minutes. D9220 – one unit and D9221 – one unit

Claims submitted with time units for dental anesthesia services will be returned.

**Alcohol and Drug Abuse Treatment Service**
BCBSNE member contracts do not provide benefits for codes H0001-H0050. If any claims are received with any of the H codes, the service will be denied as member liability.

**Alcohol and/or drug assessments must be billed using 99408 or 99409.**

Code 99408 is defined as alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST) and screening and brief intervention (SBI) services, 15 to 30 minutes. Always bill with a unit of one.

Code 99409 is defined as alcohol and/or substance (other than tobacco) abuse structured screening (e.g. AUDIT, DAST) and screening and brief intervention (SBI) services, greater than 30 minutes. Always bill with a unit of one.

Alpha Prefix Change for Wal-Mart Members
On January 1, 2010, all Wal-Mart membership was transferred to Arkansas Blue Cross Blue Shield. Wal-Mart members received new I.D. cards with the Alpha Prefix WMW. As a result, Alpha Prefixes WLA, WMR and MRT are no longer valid.

For the first six months of 2010, claims submitted with an invalid Alpha Prefix of WLA, WMR or MRT were accepted, and systematically directed to Arkansas Blue Cross Blue Shield for processing through BlueCard. The special handling of this account afforded the members and providers the opportunity to update their insurance information.

To date, it has been reported that over 750,000 claims for Wal-Mart members have been submitted with an invalid Alpha Prefix. Effective with dates of service July 1, 2010, claims received with an invalid Alpha Prefix will be returned to the provider for correction.

Whenever possible, ask to see your patient’s I.D. card at the time of service. Be sure you have the most up-to-date insurance information on file and are submitting your claims with accurate information.

Provider Satisfaction Survey is Underway
The Blue Cross and Blue Shield Association’s survey vendor, Synovate, is contacting network providers at random to answer questions related to satisfaction with the BlueCard Program through September 30, 2010.

This survey provides the Association and its Plans with valuable information regarding provider satisfaction levels, key drivers of satisfaction and emerging market issues impacting provider communities.

If your office is contacted, we encourage you to participate in the survey.
Upcoming Address Validation

On an annual basis, the TRICARE program requests that BCBSNE send out an address validation of network providers. Watch your mail this fall for documents requesting verification of practice locations, e-mail addresses and active practitioners. Only contracted providers will be requested to verify their status.

Why do we want e-mail addresses? TriWest, the administrator of TRICARE, has set a standard to communicate with the right person at the right time. The fastest and easiest way is through e-mail blasts. TriWest promises to not distribute your e-mail address to other companies, to not send spam e-mails or to overload your e-mail account.

For questions regarding the address validation, please contact Chris Sorensen, TRICARE Provider Liaison at (402) 392-4201 or chris.sorensen@bcbsne.com.

Electronic Remittance Advice (ERA) Can Reduce Your Paperwork

The Electronic Remittance Advice (ERA) can help improve your business office workflow and productivity. ERA can be automatically loaded into your accounts receivable system, depending on your software.

Also known as the 835 transaction, your ERA can be a secure and reliable alternative to manually posting claim adjudication information to an accounts receivable software program and allow you more time to focus on caring for your patients.

How does it work?

Containing the same information on claim payment, deductible and co-insurance, ERA is the electronic equivalent of the paper remittance advice (also known as an Explanation of Benefits or EOB) and provides details on how your claims were processed.

As soon as your TRICARE claims finalize, your ERA is generated.

What are the benefits of ERA?

Depending on your practice management system and internal workflow, ERA can improve your business office workflow and productivity by:

- Eliminating the need to manually enter and process paper EOBs
- Eliminating errors associated with manual posting of paper EOBs
- Eliminating the need to store and file paper EOBs
- Decreasing the time spent reconciling accounts receivable

How can I start receiving ERA?

To enroll, please download and complete the Electronic Remittance Advice (PDF) document or the fill and print version located at www.triwest.com, under the “Find Form” tab and return it to:

WPS Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128

When you choose to receive ERAs, your files will be sent to you in the American National Standards Institute (ANSI) X12 835 format, version 4010A1, and can be downloaded from the WPS Bulletin Board System (BBS) or through the secure website at www.triwest.com/provider.

For further information about ERA, refer to the 835 Electronic Remittance Advice Transaction guide located in the EDI/Secure Web area of www.triwest.com/provider.
New Faces in Health Network Services

Health Network Services is pleased to introduce three of our newest staff members:

**Natalie Dennes – HNS Research Coordinator**
Natalie has worked for BCBSNE since 2007, most recently as an adjuster. In HNS, she puts her customer-first attitude to work. Natalie enjoys doing anything that involves her six-year-old daughter and three-year-old son, in addition to reading, following political issues and shopping.

**Josh Wiens – HNS Business Analyst**
After joining BCBSNE in 2004, Josh has worked in provider-related areas throughout the company. He most recently worked in Information Systems as a Business/Systems Analyst, where he worked on various provider-related projects. When he’s not working, he's busy finishing his Master’s degree in Health Care Administration and spending time with his German Shepherd, Sampson.

**Patricia Cavanaugh – Health Network Consultant**
Patricia joined BCBSNE in March 2010 and brought with her 30 years of insurance experience, along with knowledge in customer service, provider relations and provider contracting. Patricia enjoys spending time with her family and enjoys every moment they are together.

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**Go Green With BLUE**

Start using electronic remits and funds transfers today! By using electronic remits and funds transfer, you gain the following benefits:

- Save money and time with electronic posting
- Save natural resources by reducing the use of paper and fossil fuels used to transport paper remits
- 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/or Electronic Funds Transfer, fill out and fax us one of the following forms, located on the Provider page at bcbsne.com, under “Forms”:

- Electronic Remittance Advice and Electronic Funds Transfer Enrollment Form
- Electronic Funds Transfer Enrollment Form
- Electronic Remittance Advice

**If you have any questions, please contact:**
- **Sean Blair** (serves offices in Omaha and South of I-80)
  - Phone: (402) 392-4205 or (888) 233-8351 (options 4, 1)
  - E-mail: sean.blair@bcbsne.com
- **Josh Wiens** (serves offices in Omaha and South of I-80)
  - Phone: (402) 982-8727 or (888) 233-8351 (options 4, 2)
  - E-mail: josh.wiens@bcbsne.com

**Go Green with Blue Tip:** Check for blank pages.
Before you print off something, check that there are no blank pages in the file you have created.
Source: *100 Ways to Save the Planet without Leaving the Office*
Simon Melhuish, Editor
Countdown to 5010 – Update

The Health Insurance Portability and Accountability Act (HIPAA) requires the adoption of specific standards for electronic healthcare transactions (claims, eligibility inquiries, claims status requests and responses).

Per federal regulation, all healthcare entities (insurance plans, clearinghouses and providers) must transition from the current standard, 4010A1, to 5010 on January 1, 2012.

While the 2012 deadline appears to be distant, significant work must be done to successfully prepare for this mandatory transition.

As part of the preparation, BCBSNE sent a survey in mid-June to selected providers to obtain feedback on testing preferences. Of those providers who responded, the following dates were ranked in order of preference:

**First Preference** – October 1-15, 2010  
**Second Preference** – October 16-31, 2010  
**Third Preference** – February 16-28, 2011

Please note that before selecting the final testing dates, we would like to obtain feedback from additional providers. We will reach out to those who have not responded to previous survey requests.

The benefits of the 5010 transition include:
- Streamlined content
- Consistent data representation
- Formatting that will be ready to accept new ICD-10 codes

In addition, numerous fixes to 837 (claims), 27X (inquires) and 835 remittance advices will be implemented.

We encourage you to contact your respective clearinghouse about the preparations they are making regarding the 5010 business requirement. This may involve a coordinated effort between you and your clearinghouse.

If you have questions about the 5010 transition, please e-mail HIPAA5010inquires@bcbsne.com.

BCBSNE will continue to keep you informed in future communications and “Update” newsletters on this important transition throughout the year and into 2011.
NPI Simplifies Claims Processing

It is becoming increasingly necessary for providers to have a National Provider Identifier to allow for greater ease in claims processing and for a smooth transition to our new claims processing system. **Starting in January 2011, Medicare will require providers to submit their NPI with claims information.**

For more information on obtaining an NPI, visit the Regulations and Guidance page, located under the National Provider Identifier Standard section at [cms.hhs.gov](http://cms.hhs.gov).

Once you have your NPI, complete the appropriate NPI notification form (NPI Individual Notification or NPI Organization Notification) and mail or fax it to:

Blue Cross and Blue Shield of Nebraska  
ATTN: HNS  
PO Box 3248  
Omaha, NE 68180-0001  
FAX: 402-343-3455

The NPI notification forms are located on the Provider page at bcbsne.com, under “Forms.”

Use Box 32 on the CMS 1500

BCBSNE now uses the National Provider Identifier to identify the rendering provider. Since we no longer use the assigned five-digit assigned provider numbers, the information entered in Box 32 is vital.

If an address is present in Box 32 and corresponds to the rendering provider’s practice address that we have on file, then the appropriate provider record is selected and the claim is processed. If an address is present but is not on file with BCBSNE, the claim is sent to Health Network Services to add the location. HNS will not add a location if it is a patient’s home address. If box 32 is blank, it is presumed that the address in Box 33 is the physical location.

The requirements for Box 32 include:

- If the address in Box 33 serves as both the billing/payment location and service location, Box 32 may be left blank
- When the services are rendered or delivered from a location that is not the same as the billing/payment location, Box 32 must be completed with a physical address (clinic/facility/store name with street address and city, state and zip code; a P.O. box is not valid)
- Ambulance providers should populate the “destination” in Box 32
- Never put a patient’s home address in Box 32

Please contact your BCBSNE Health Network Consultant if you have questions.

Process Improvement for Behavioral Health Practitioners

If you are a behavioral health practitioner whose licensure is not recognized by Medicare, but your services are billable to BCBSNE, you may have experienced difficulty in the past when filing your secondary to Medicare claims to BCBSNE for processing.

A process improvement has been implemented that will result in a smooth claims experience. The process improvement will allow your claims to be processed without asking you to provide an Explanation of Medicare Benefits (EOMB) or a copy of a letter from CMS stating your services are not billable to Medicare.

Contact your BCBSNE Health Network Consultant if you have any questions.
Eliminate Health Care Fraud and Abuse

BCBSNE has been committed to preventing, detecting and investigating fraud, waste and abuse. We continue to stay true to that commitment to stay protected against rising health care costs. Over the past 18 months, BCBSNE’s Special Investigations Unit has saved BCBSNE an overall total savings of $20.6 million, mostly thanks to tips received through our fraud prevention hotline.

As a valued BCBSNE provider, what can you do to prevent fraud and abuse? Let BCBSNE know when a person:

• Continues to use their BCBSNE I.D. card following coverage termination
• Loans an I.D. card to a person not entitled to it
• Adds another person not eligible for coverage on his or her BCBS membership

We do understand that a difference between your records and the members’ records doesn’t necessarily mean fraud has been committed. However, please contact us about the discrepancy so we can determine if fraud truly has been committed.

We offer two confidential and anonymous ways to contact us:

**Online** — Fill out the form located at bcbsne.com on the “Providers” page, under “Reporting Fraud” and send it to us electronically. This form is both secure and encrypted, and our system won’t see your e-mail address.

**Phone** — Call the Special Investigations Unit at (877) 632-2583 Monday through Friday, 8:30 a.m. – 4:30 p.m. Central Time.

Your diligence in detecting fraud and abuse can protect our members and keep health care costs from rising.
### Inside update

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

**No Refund Requests after 18 Months**
February 2010

**General Coding Reminders to note**
October 2009

**Prioritization of Preauthorization Requests**
August 2009

**Submit Exact Member I.D. Number to Prevent Claim Rejection**
June 2009

**Highlights from Recent Issues Online:**