Provider Manual

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PRV20344-2311

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Introduction

This manual provides helpful contact information, valuable resources, claims processing and operational information, as well as information about provider networks and programs. The content of the manual is intended to be general and applicable to providers of all specialties.

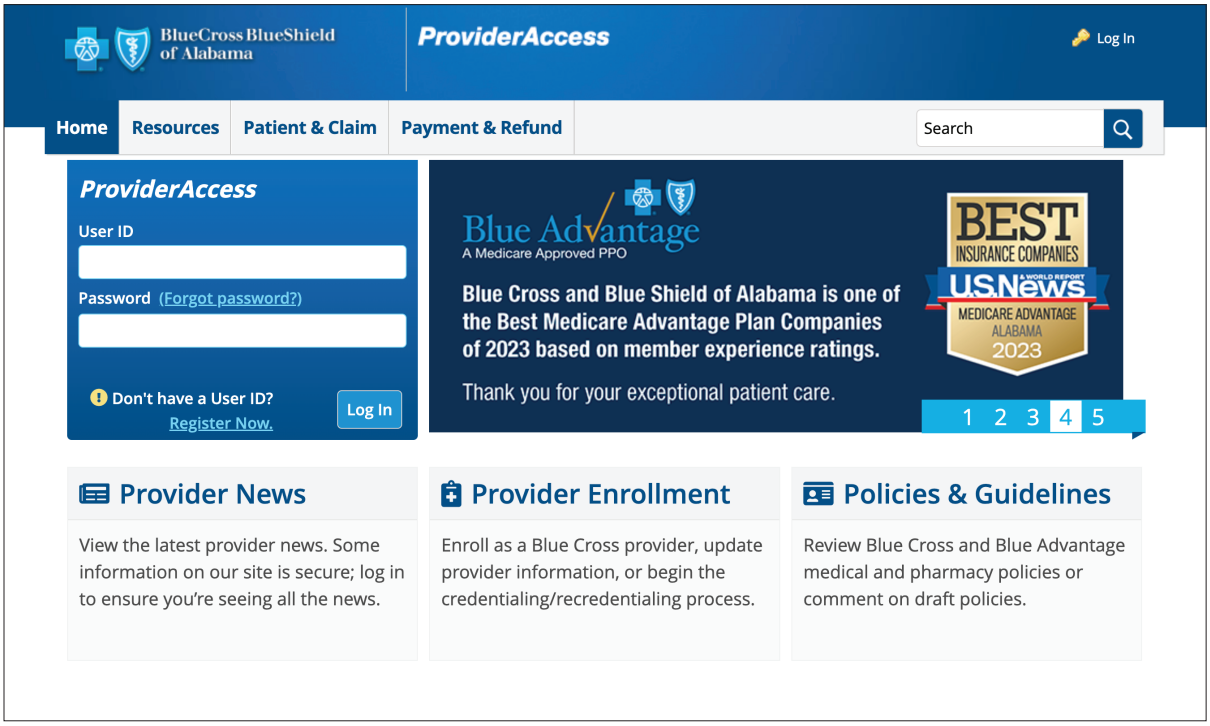
You should be able to obtain answers to nearly all of your questions related to your patients and Blue Cross and Blue Shield of Alabama transactions using our provider website, *ProviderAccess*, at **AlabamaBlue.com/Providers**, or your practice management system. *ProviderAccess* offers a variety of important information at your fingertips, as well as tools and resources to help you operate your practice and care for your patients.

Consultative Services

Blue Cross Provider Networks and eSolutions Consultants work together to deliver the best possible service to you. Learn more.

Provider News and Resources

Our website provides you with many useful forms, as well as links to our provider publications and manuals. Additionally, the website offers information about member eligibility and benefits, claims, valuable webinars and more. You can also receive the latest provider news and updates. Be sure you are registered for *ProviderAccess* by clicking Register Now on the home screen in the Log-In box. The email address you enter in your profile will be used to send to you notifications when new articles and important updates are posted on our website. Be sure we have a current email address on file for your practice as well as appropriate user roles designated.



General Operational Information

Clinical Information Exchange

Provider eSolutions promotes and supports the bidirectional secure exchange of clinical data through standard protocols (such as Direct Messaging, SFTP).

Current clinical data exchange opportunities include:

- **Care Alerts –** Notify providers when an attributed patient has an emergency room visit or is admitted to or discharged from a hospital.
- **Electronic Medical Records (EMRs) –** The ability for practices to submit electronic medical records.
- **Lab Data Exchange –** The process of data submission by labs to Blue Cross. Here is a list of our **Lab Partners**.
- **Biometric Feeds –** Standard Blue Cross layout to transmit vital signs and other clinical data.

Healthcare providers can conduct HIPAA-compliant transactions with Blue Cross using an **approved EHR vendor**.

Eligibility & Benefits and Referrals

Blue Cross and Blue Shield of Alabama providers have options available for accessing member eligibility and benefits for in-state and out-of-state Blue Cross and Blue Shield members. Member eligibility information includes effective dates of coverage; primary, secondary or tertiary contract status; waiting periods; and other important eligibility information. Benefit details include information such as deductible and out-of-pocket amounts, copays, coinsurance, referral or precertification requirements and benefit limitations.

Providers can access this information through their electronic practice management software and our *ProviderAccess* website.

Some Blue Cross and Blue Shield of Alabama contracts require members to utilize a primary care physician and referrals. Applicable providers may submit and view referrals via their electronic practice management software or *ProviderAccess*. Instructions for submitting referrals via *ProviderAccess* are available.

Virtual Identification Cards

Blue Cross members can access virtual identification (ID) card(s) by logging in to *my*BlueCross on the Alabama Blue mobile app. This program will give members the ability to email an image of their card(s) directly from the Alabama Blue app to their healthcare providers, if needed. Members must be registered for *my*BlueCross in order to access this feature. An example of what a virtual card looks like is on the right. Providers can view an image of the ID card for Blue Cross members on *ProviderAccess* in Eligibility & Benefits.

Electronic Transactions

Provider eSolutions (formerly EDI Services) provides support to healthcare providers and practice management and electronic health record (EHR) vendors (Information for Vendors/Clearinghouses), helping to ensure that electronic transactions for our members are processed quickly and efficiently.

We support many electronic transactions, including:

- **Claims (837)** – See our Standard Companion Guide Related to Batch Processing – Claims, Text Audit Report (TAR), 277HCCA and 999s
  - **Note:** if using a vendor/clearinghouse to submit your claims, Blue Cross may not receive the file the day you submit it to your vendor/clearinghouse
  - 999s – Returned within 2 hours after file claims file is submitted
  - Text Audit Reports (TAR) / 277HCCA – Claim file received before 3:30 p.m. Central Time will be available the following business day through your practice management system and/or *ProviderAccess*. After 3:30 p.m. Central Time, they will be available the next business day. Example: Monday after 3:30 p.m., reports will be available Wednesday.
- **Eligibility and Benefits (270/271)** – See our Standard Companion Guide Related to Real-Time Processing
- **Remittance Notices (835)** – See our Standard Companion Guide Related to Batch Processing – Remittances

Healthcare providers can conduct electronic transactions with Blue Cross two ways:

- An approved practice management vendor or clearinghouse
- Our website, *ProviderAccess*
  - If you haven't already done so, register now for *ProviderAccess*.
  - Many parts of our website are secure. Always log in to *ProviderAccess* to ensure that you're able to access all functions and information.
  - Contact Provider eSolutions if you need help with our site: Ask-EDI@bcbsal.org or 205-220-6899.

Remittances

A remittance shows payment, denial and certain other information concerning submitted claims processed by Blue Cross. The remittance is listed by the provider's NPI and Tax ID, as well as patient names and contract numbers. Remittance dates occur every Thursday unless it is a holiday, in which case a notification with an alternate date is provided.

Remittance copies can be obtained electronically from the Blue Cross website through *ProviderAccess*, from your practice management software and/or the IVR at 1-800-648-9807. If the remittance is more than six months old, the IVR will advise that there is no matching information. When this happens, additional options will be presented, including the option to request a copy of the remittance.

When a rejected claim appears on a remittance, it will state the reason for the rejection by way of Claim Adjustment Reason Code (CARC) or Remittance Advice Remark Codes (RARC). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) claim rejection code reasons are listed at wpc-edi.com/reference. Some reasons for rejections include benefit restrictions and contract cancellations as well as procedure code and/or diagnosis code combination issues.

Medicare Remittance Date Required on Secondary Claims

When Medicare is the primary insurer and Blue Cross is secondary, claims processed by Medicare should automatically forward, or crossover, to Blue Cross for processing. If there are situations where a provider needs to submit a secondary claim directly to Blue Cross, here are some guidelines:

- Providers must wait 30 calendar days from the Medicare primary remittance date before submitting the claim to Blue Cross. **Claims submitted prior to this 30-day period cannot be adjusted and will have to be resubmitted.**
- The Medicare remittance date must be included on the Blue Cross claim.
- For faster processing, secondary claims should be submitted electronically through your practice management software system or eClaims on our website.

Refund Requests and Overpayments

Refund Requests

When Blue Cross discovers an error in payment, a refund request is made to recoup the overpayment from the provider. Providers should promptly refund these amounts. Refund amounts can be paid in full or settled through the provider's future remittance payments.

A Refund Billing Invoice is available for most refund requests. Typically, Blue Cross sends up to two notices within a 45-day period to the provider. If we do not hear from the provider within the 45-day period, automatic deductions from the provider's future remittance payments begin.

If there is a dispute regarding the refund request, contact Blue Cross during the 45-day period to avoid automatic deductions from your remittance.

Here are ways to dispute a refund request:

- Sign into *ProviderAccess* and select Payee Functions.
- Contact Customer Service.
- Send a written request to the address below:

  Provider Billing
  Blue Cross and Blue Shield of Alabama
  Post Office Box 362130
  Hoover, Alabama 35236-2130

Overpayments

If you discover an error in payment, please complete the Voluntary Overpayment Return Form and attach it to your check. Checks should be made payable to Blue Cross and Blue Shield of Alabama. For overpayment made on a specific claim, be sure to provide the patient's name, contract number and the date of service.

Payment can also be made by scheduling the claim(s) to automatically deduct from future remittances via *ProviderAccess*. You can mark an entire invoice or individual claims to deduct.

Time Limits for Filing Claims

All groups have time limitations for submission of claims. Providers should file claims as promptly as possible. If you need verification of time limits, you may access this information through your practice management software or *ProviderAccess* Eligibility and Benefits.

The following are examples of time limitations for some groups:

- State of Alabama claims must be 365 days from incurred date.
- Claims for many regular Blue Cross and Blue Shield of Alabama contracts must be submitted no later than 24 months after the date the services were rendered or expenses were incurred.
- Other groups may vary the time filing limitations, such as 15 months from incurred date or the end of the calendar year in which the services or expenses were incurred.

Note: Groups' time limits for filing are subject to change. You should always verify the time limit through *ProviderAccess* Eligibility and Benefits.

Payment for Medical Records Requests

Refunds and medical records payments are made via electronic funds transfer (EFT), which is available to providers and their vendors. Providers can register for EFT through our vendor, Zelis. Please visit https://bcbsal.payeehub.org to register for EFT. Vendors also can contact Treasuryupdates@bcbsal.org for EFT signup information. For additional details, review the Medical Record Requests webpage on *ProviderAccess*.

Participating in our provider networks includes the requirement to submit medical records for audit and other mandated purposes.

Laboratories, DME/HME and Specialty Pharmacy

Healthcare providers should generally file claims for all Blue Cross and Blue Shield members to the local Blue Plan in the state where the provider is located. However, Blue Cross and Blue Shield Association claims filing guidelines may differ based on the type of provider and service, such as for ancillary providers. Ancillary providers should follow these helpful instructions for filing claims.

Provider	Where to file claims
Independent Clinical Laboratory (Lab)	The Blue Plan in the state **where the referring provider is located**, regardless of your contract status with the Plan.
***DME/HME**	The Blue Plan in the state where the equipment is ***delivered*** or ***purchased*** (at a retail store), regardless of your contract status with the Plan.
Specialty Pharmacy	The Blue Plan in the state **where the ordering physician is located.**

* **FOR DME -** If the place of treatment is the retail store (place of treatment 17), the claim should be filed to the Plan in the state where the store is located. If the place of treatment is the home (place of treatment 12), the claim should be filed to the Plan in the state where the member lives. Please note, the Service Facility Location address in the corresponding electronic claim should be an Alabama address when billing services to Alabama.

Claims for these ancillary services are subject to medical policy and fragmented coding edits in place at the Blue Plan to which they are filed. The ancillary claim filing rules apply regardless of the provider's contracting status with any Blue Plan. Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment for noncovered services directly from the member.

Blood Collection Fee - Venipuncture

Blood collection fees are the only collection fees covered for venipuncture. Collection of throat cultures, Pap smears, etc., are considered part of the office visit.

Benefits are only provided when an in-network lab is utilized. It is not appropriate to bill for or up-code an office visit due solely to the collection of a specimen.

Coordination of Benefits (COB)

Because spouses and dependents are often provided insurance coverage under multiple plans, COB rules were developed to help prevent the overpayment of health and dental benefits. COB rules establish which insurance plan will pay first (the primary plan) and which will consider any remaining amounts not paid by the primary plan (the secondary plan).

Coordination of payments helps reduce the possibility of members profiting from duplicate insurance coverage, as well as preventing healthcare providers from receiving duplicate payments from two insurance plans. In doing so, COB helps control the rising costs of health and dental insurance.

Benefit Methods

In general, the purpose of COB is for the secondary plan to pay benefits not paid by the primary plan. However, there are several different ways, or COB Benefit Methods, to calculate the secondary payment.

- **Model COB:** Model COB compares primary liability to secondary liability and selects the most cost-effective payment on a claim-by-claim basis. Primary liability refers to the amount that would have been paid if the contract were primary. Secondary liability is simply the total charge less what the other insurance carrier (OIC) paid.
- **Non-Duplication COB:** Many self-funded groups choose the Non-Duplication COB method. This method is more cost-effective for the group, often resulting in less paid in secondary benefits than would have been provided with Model COB. The secondary benefit payment with Non-Duplication COB is determined by calculating primary payment, subtracting the OIC payment, and paying the remaining amount, if any.
- **Secondary Limit COB:** The secondary benefit determination under Secondary Limit COB is made by first subtracting the OIC payment from the total charge. Contract benefits are then applied to the remaining amount. All copayments, deductible, pricing (e.g., UCR, PMD, etc.) and benefits apply unless noted within eligibility and benefits available through your electronic practice management software or *ProviderAccess*.

Determining the COB Benefit Method Used

The specific COB method used for your patient can be found under the "Coordination of Benefits" category of the Summary Plan Description on *ProviderAccess*. This site also indicates whether the patient has primary or secondary coverage under the contract being viewed.

Definitions

Group Plan: This term normally applies to employer-sponsored health and dental insurance. However, it may apply to any group plan by which dental, medical or other healthcare benefits are provided by an employer, fraternal organization or franchise insurance coverage.

Group plans include most Blue Cross and Blue Shield Plans, other prepayment coverage, any coverage under labor-management trusted plans, union welfare plans, employer organization plans, employee benefit organization plans, any governmental program or any coverage to which coordination of benefits may be applied by law or regulation.

Group plans generally include COB provisions and should coordinate benefits.

Non-Group Plan: This term normally applies to individually purchased insurance. Generally, non-group plans do not coordinate benefits with other plans. See the next page for more information regarding non-COB Plans.

Non-COB Plans

Blue Cross does not coordinate with the following types of insurance plans:

- Non-group plans
- Individual or family supplemental insurance policies
- Subscriber purchased contracts
- School accident-type coverage
- Individual or family prepayment, group payment, or individual practice claims
- Federally funded insurance

There is no coordination of benefits with these companies because they are either:

- Direct pay contracts where the subscriber buys the coverage and, therefore, are not a group benefit acquired through an employer, or
- Federally funded.

United States military personnel and retirees may have coverage through Tricare (formerly Champus). According to their rules, this coverage always pays secondary to any other healthcare coverage. Therefore, Blue Cross coverage is always primary, as if no other coverage exists.

Order of Benefit Determination

When both carriers include coordination of benefits in their contracts, payment order is determined by a series of rules that were developed by the National Association of Insurance Commissioners and adopted by most state insurance departments including the Alabama Department of Insurance (see Alabama State Regulation 128) and plan administrators. Regulation 128 contains an order of benefits determination referred to as the "Birthday Rule."

Generally, the Birthday Rule is an accepted guide for most plans in determining the order of benefits. The plan of the parent who has the earliest birthday in the year is primary. If the parents have the same birthday, the plan that has provided coverage for one of the parents the longest is the primary plan.

The PMD Contract

There are cases when primary coverage is other than a Blue Cross and Blue Shield of Alabama contract or is a non-Preferred Care Blue Cross and Blue Shield of Alabama contract. In these situations, the secondary coverage may be Blue Cross and Blue Shield of Alabama. Where the secondary coverage is a Preferred Medical Doctor (PMD) contract, the PMD agreement is still in effect and patients should not be billed for services over the PMD fee schedule.

Two Blue Cross and Blue Shield of Alabama Contracts

When a member is covered by more than one Blue Cross and Blue Shield of Alabama group contract, benefits are provided under both contracts applying the principles of coordination of benefits.

When a member is covered under a Blue Cross group contract and a Blue Cross non-group contract, benefits are provided under both contracts by applying the principles of coordination of benefits, except the group contract is always the primary payer.

Note: The State of Alabama group requires us to pay primary on both contracts.

When a member is covered by more than one non-group Blue Cross contract, benefits are provided only under the one such contract providing the greatest coverage.

Work-Related Injury Overview

The Work-Related Injury (WRI) Plan covers work-related injuries and illnesses. This benefit is not subject to deductibles, copayments or maximums. WRI coverage for work-related injuries must be a benefit of the patient's group coverage and does not apply to all contracts.

Filing Guidelines

- For groups that have WRI coverage, written precertification for inpatient hospital admission is required if requested by the group.
- Must indicate on claim form that services were for a work-related injury or illness.
- Include date of accident on claim.
- In certain claims, use WRI prefix and employee's Social Security number as the contract number on the claim. **Note:** In cases involving members that have multiple injuries with different groups, the member is assigned a plan contract number with the WRI prefix.
- Indicate on claim if other insurance is involved.
- WRI contracts always pay as primary. There is no coordination of benefits (COB).

Important Information

- Member does not receive an explanation of benefits (EOB) on his or her claims.
- Contact Provider Customer Service if a member requests a copy of his or her claim. Be prepared to tell Provider Customer Service why the patient requested the claim.
- Contact Provider Customer Service if a patient asks you to endorse a check issued by another payer.
- Contact Provider Customer Service if you receive duplicate payments from two payers for the same injury.
- WRI claims are provider payable.

Subrogation

The majority of our contracts contain a subrogation and reimbursement provision. Subrogation is the substitution of one party for another when the injured party has a legal claim against another party. It allows Blue Cross to recover from any other payer the cost of our healthcare benefits. For additional details, review the Subrogation Information for Hospitals and Providers webpage on *ProviderAccess*.

Accident-Related Claims

When treating a member who has been involved in an accident of any nature, claims should be immediately filed with Blue Cross and Blue Shield of Alabama. In accordance with our PMD and Participating Hospital Contracts, it is Blue Cross' policy to consider each claim under normal contract benefits and make payment to the provider.

For more information, review the Subrogation Information for Hospitals and Providers webpage on *ProviderAccess*.

Workers' Compensation

Workers' Compensation is an exclusion in most contracts and payment by Blue Cross will be excluded. If a claim is submitted, paid in error, and the physician finds out that it is related to an on-the-job injury, he or she should reimburse Blue Cross, in most cases. For any questions concerning whether we are due the refund, call Provider Customer Service.

Workers' Compensation is an exclusion in our group healthcare contracts, with the exception of a few groups that are covered under the Work-Related Injury Plan. The member's contract number will begin with prefix WRI if he or she is covered under the Work-Related Injury Plan.

Any charges submitted to Blue Cross for payment of a work-related injury should be non-covered. They will process with an adjudication code of 910 (Treatment of work-related injuries are not covered by this contract. These charges should be submitted to the patient's Workers' Compensation carrier).

If payment has been made, Blue Cross will review the group healthcare contract and take action to seek recovery on any work-related claims paid.

If an employer has less than five employees, it is not required by law to carry Workers' Compensation insurance for its employees.

Telephone calls or inquiries related to Workers' Compensation issues will be directed to the Workers' Compensation Recovery Area.

Physicians' Current Procedural Terminology (CPT) code 99080 should be used to file special reports such as insurance forms or in cases where there is more information than conveyed in the usual medical communications or standard reporting form.

CPT code 99080 is payable once per case (per individual patient injury) when billed related to Workers' Compensation claims. This code is only covered by contracts with the 24-Hour Coverage plan and the WRI prefix. CPT code 99080 is not listed on the PMD fee schedule and will therefore be paid based on the Workers' Compensation State-mandated Fee Schedule.

Consultations vs. Referrals

A consultation is a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition/problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

In order to bill for the consultation, the following criteria must be met:

- The service must be medically necessary.
- The service must be made by a physician or other appropriate source, through a written or verbal request, and documented in the patient's medical records by either the consulting or requesting physician or appropriate source.
- The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.
- In an inpatient setting, the request can be documented as part of an order in the patient's hospital records or as part of the requesting physician's plan in his/her progress note.
- The consultation must include the history, examination and analysis of the health problem.

A **consultation** initiated by a patient and/or family, and not requested by a physician or other appropriate source is not reported using the consultation codes but may be reported using the office visit, home service or domiciliary/rest home care codes as appropriate.

A **consultation** occurs when, for example, a dermatologist refers a patient to a second dermatologist for an opinion on how to best treat the patient's acne scarring. Based on the reported opinion of the second dermatologist, the first dermatologist then resumes the treatment of the patient, and the second dermatologist bills for a consultation.

A **referral** is the process whereby a physician or other qualified healthcare professional who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician or other qualified healthcare professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other qualified healthcare professional transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate.

A **referral** occurs when, for example, a dermatologist refers a patient to a second dermatologist for the actual treatment of scarring. The second dermatologist assumes the care of the patient.

In the first example, if the attending physician reviews the consulting dermatologist's recommendations and asks him/her to assume responsibility for treating the patient's acne scarring, the consultation has resulted in a referral. It is still appropriate for the consulting dermatologist to bill a consultation for the initial patient encounter. There may be occasions when a patient is sent for a consultation and elects to have the consulting physician begin treatment on the day of the initial encounter. For example, the patient lives in a different town

than the consulting physician and does not wish to make a second trip to the consulting physician, or due to the patient's condition, immediate treatment is necessary. These encounters could be billed as consultations when the above-stated criteria are met.

If subsequent to the completion of a consultation the consultant assumes responsibility for the management of a portion or all of the patient's condition(s), the appropriate Evaluation and Management services code for the site of service should be reported.

Follow-up visits in the consultant's office or other outpatient facility that are initiated by the consultant or patient are reported using the appropriate codes for established patients, CPT codes 99211-99215 or 99231-99233. If an additional request for an opinion or advice regarding the same or a new problem is received from another physician or other appropriate source and documented in the medical record, the office consultation codes may be used again.

Diagnosis Codes

An International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) code must be used to identify each patient's diagnosis or nature of illness or injury. Diagnosis codes are very important in making benefit determinations. They are used to evaluate whether or not services are medically necessary, if a condition is pre-existing, if Worker's Compensation is applicable, and for screening medical emergencies. Providers should use the most recent version of the ICD-10-CM coding book and should code to the highest level of specificity for the diagnosis. It is critical that Blue Cross receive complete and accurate coding data to properly indicate our members' health status. This information drives the development of care management strategies and identifies patients most in need of resources. It also conveys the complexity of our patients' health or "risk," which will impact future premium rates and provider incentive programs. Visit the Coding Corner webpage on ProviderAccess for additional information about risk coding.

Current Procedural Terminology (CPT®) Code 99211

As a reminder, many Blue Cross and Blue Shield of Alabama contracts only cover services billed with code 99211 when the physician is present and personally provides a medically necessary service that is documented in the patient's medical record.

The exception to this is employer groups that provide benefits for nurse practitioners or physician assistants. Always check a patient's benefits in *ProviderAccess*. If the physician is not present or does not personally provide a medically necessary service, do not bill CPT code 99211 for the visit. Examples of this occurrence include the following:

- Billing an office visit with CPT code 99211 for laboratory work evaluation without the physician seeing the patient
- Services performed only by a nurse without the physician also performing a service
- Any other service performed by a physician extender without actual physician intervention

Although the CPT code book specifies that office visit procedure code 99211 may be billed for visits that may not require the presence of a physician, a physician should not bill an office visit to Blue Cross if only a physician extender sees the patient.

This guideline applies whether or not the physician is in the office at the time the service is performed. If the patient has Preferred Care benefits, the Preferred Care provider should not bill the patient for the visit since this is a nonbillable service rather than a noncovered item. Please make sure your physicians, nurses, assistants and billing personnel are aware of these guidelines.

Modifier 25

Modifier 25 – Significant, Separately Identifiable Evaluation and Management (E&M) Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Services

The purpose of modifier 25 is to indicate that a significant, separately identifiable E&M service was performed by the same physician, or physician with the same physician specialty and tax identification number, on the same day of a procedure or service.

- The E&M service has to be above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
- The E&M service must meet the key components: history, examination and medical decision-making.
- This modifier should not be used to report an E&M service that resulted in a decision to perform surgery.

Modifier 25 should only be appended to the E&M service on the same day as a minor procedure or service (procedures/services with 0- and 10-day global periods) or National Correct Coding Initiative (NCCI) edits.

Modifier 25 can be used when all of the following criteria are met:

- E&M involves separate and unique conditions, services, procedures, incisions, excisions or anatomical sites.
- The procedure and medically necessary E&M occur on the same day by the same provider.
- A decision is made to perform a minor procedure. A minor surgical procedure is one that has a global aftercare period of 0 - 10 days based on universally recognized standards.
- The E&M service is above and beyond the usual preoperative, intraoperative, or postoperative care associated with the procedure that was performed and is in no way related to the procedure code submitted.
- E&M visit is problem-oriented and stands alone as a billable service.

Modifier 25 should not be used in the following scenarios:

- An E&M code is billed with major surgical procedures, chiropractic manipulations, or polysomnography. A major surgical procedure is one that has a global aftercare period of more than 10 days based on universally recognized standards.
- Lab or x-ray services are the only other services provided in addition to the E&M service.
- The sole reason of the visit was for the procedure.
- The E&M service is not above and beyond the primary purpose of the patient encounter.
- Documentation does not support the definition of the modifier.
- To bypass a fragmented coding edit.

Diagnosis Coding for Screening Tests

Screening is the testing for disease or disease precursors in seemingly well individuals so that early detection and treatment can be provided for those who test positive for a disease.

The testing of a person to rule out or confirm a suspected diagnosis because the patient has some sign or symptom is a diagnostic examination, not a screening. In these cases, the sign or symptom is used to explain the test reasoning.

Should a condition be discovered during the screening, then the code for the condition may be assigned as an additional diagnosis.

HIPAA Privacy and Nonfiled Claims

Due to HIPAA and its implementing regulations and other guidance,45 CFR, Section 164.522 (Rights to Request Privacy Protection for Protected Health Information), Blue Cross has a policy regarding claims that members do not want filed. If a member instructs the provider not to file a claim for services through Blue Cross, a provider can honor this request and accept payment. However, a "Notification of Nonfiled Claims" form should be signed by the member prior to accepting payment.

Notification of Noncovered Services

As noted in Section 4.5 of the Preferred Medical Doctor (PMD) contract, the physician is responsible for notifying the patient of noncovered services or those services not medically necessary for the treatment of his/her condition. Before performing or ordering these services, you should obtain the patient's signature on a written statement of noncovered services. This document should explain to the patient which services they will be responsible for and the amount of the charge.

To help you notify patients of noncovered services, a sample form called the "Notification of Noncovered Services" is available on our website in the forms section.

An additional form may be drafted to address noncovered services, such as cosmetic surgery or non-medically necessary services.

Depending on the subscriber's contract, these services may be eligible for coverage under Major Medical but are not payable as a PMD benefit:

- Durable Medical Equipment and Supplies
- Mental and Nervous Conditions
- Physical Therapy
- Allergy Testing and Treatment*

***Note:** Allergy testing and treatment are covered under Major Medical for most groups. If you are doing allergy testing and treatment, be sure to verify how the patient's contract handles allergy services.

Section 4.8 of the PMD Agreement states:
"Physician agrees to complete and file on a timely basis all claims for benefits for Medical Services rendered to members."

It is best to file all claims so you as the provider will receive a remittance and the patient will receive an explanation of benefits stating the service is noncovered. Please note that credit card payments can be made for copayments and deductibles; however, a member may not be charged for a noncovered service unless you have obtained a signed notification of noncovered services waiver. Credit cards should not be kept on file for payment of noncovered services.

Immunization Administration for Vaccines/Toxoids

Immunization administration code(s) can be billed for each vaccine/toxoid product administered in addition to the vaccine and toxoid code(s). CPT codes 90460 and 90461 are used to report immunization administration for children through 18 years of age with face-to-face physician counseling. CPT codes 90471 and 90472 are used to report immunization administration with no face-to-face physician counseling. CPT code 90472 is an add-on code to 90471 and can be billed for each injection (i.e., if three injections are administered, CPT code 90471 is processed with one unit of service and CPT code 90472 is processed with two units of service).

Injectable Drugs

The applicable HCPCS/CPT injectable drug administration code (96372) can be billed for administration of each separate injection. The HCPCS/CPT drug code can also be billed in addition to the administration code. PMD providers are reimbursed one administrative allowance for each separate injection. If multiple drugs are administered through the same syringe, only one administration code should be billed.

Do not report 96372 for injections given without direct physician or other qualified healthcare professional supervision. To report, use 99211. Professional claims for physician-administered/distributed drugs require the NDC to be included on the claim. The NDC is required for all

drugs including, but not limited to: injectable vaccines, oncology drugs, intranasal vaccines, topical therapies, inhalation drugs, and radiopharmaceuticals and contrast agents where the NDC is available. The NDC will be required on all claims for professional providers, including non-participating providers, Blue Advantage® claims and on member-filed claims.

Some drugs have several codes assigned to indicate different strengths. If a code exists for the administered strength of the drug, use that code instead of multiple numbers of services on the code representing the lesser strength. Multiple numbers of services for a drug should only be billed when the dosage administered is greater than the specific code.

Blue Cross updates the injectable drug fee schedule on a quarterly basis, based on Average Sales Price (ASP) and Wholesale Acquisition Cost (WAC) for most drugs. Medi-Span and Redbook are the most common sources used for AWP.

New Patient vs. Established Patient

New Patient

- A patient who is new to the physician and whose medical record must be established.
- A patient who has not received any professional services within the past three years from the physician/qualified healthcare professional or another physician/qualified healthcare professional with the exact same specialty and sub-specialty who belongs to the same group practice.

Established Patient

- A patient whose records are available to the provider.
- A patient who has received any professional services within the last three years from the physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice.

Referring Physician Information

The referring physician's NPI should be provided on the claim for the following services:

- Radiology
- Pathology
- Independent Laboratory
- Physical Therapy
- Audiology
- DME

Behavioral Health

For general information on our Behavioral Health programs and New Directions Behavioral Health, visit our Behavioral Health page on *ProviderAccess*.

Lucet is an independent company providing behavioral health services to Blue Cross and Blue Shield of Alabama members.

Preferred Care and Participating Programs

Locum Tenens/Covering Physicians

Section 4.14 of the PMD Agreement states in part, "Physician shall not allow non-Preferred physicians or other allied health professionals to bill the Corporation for services using the Physician's Provider Number." Section 4.17 states in part, "Preferred general practice, family practice, internal medicine, geriatrics and OB/GYN physicians will exercise reasonable efforts to arrange for 24 hour, seven day per week call coverage."

As a general policy, the physician rendering the service should bill with his or her own provider number. In the circumstance of temporary coverage/locum tenens arrangements the physician should exercise reasonable efforts to ensure that the covering physician is PMD.

In the event that a non-PMD physician must be used, the PMD physician may bill for the non-PMD physician under his/her provider number if the services are provided on a temporary/non-routine basis such as locum tenens. If the locum tenens or covering physician replaces the physician for more than two weeks, or on a regular, ongoing basis (for example, every weekend), the covering physician should get a provider number through Blue Cross and bill under his/her own provider number. The medical records should reflect the signature style, "Doctor X covering for Doctor Y," as a matter of prudent documentation practices.

Below is a list of modifiers that may be placed on the claim following the procedure code to signify involvement in patient care by someone other than the "regular" physician. Although we do not require these modifiers be placed on the claim,any information that can help communicate involvement by another provider is considered helpful for processing.

Modifiers

Q5 - Service Furnished By Substitute Physician Reciprocal

Q6 - Service Furnished By A Locum Tenens Physician

Pass-Through Billing for Laboratory Tests

Pass-through billing is not permitted by Blue Cross. Pass-through billing occurs when tests are billed by someone other than the provider who actually performed them. The performing provider should bill for these services directly. This requirement is applicable to all in-network providers. Pass-through billing requirements may be applied to other services in the future.

Physician Referrals Out of Network

The PMD contract specifies in Sections 4.10 and 4.13 that "physicians shall refer members to preferred physicians, preferred podiatry providers, preferred laboratory, and participating hospitals. Physicians must coordinate services outside of the Preferred Provider Network with the corporation's health management medical director or his/her designee prior to referring members out of network."

Physicians Treating Members of Same Family/Household

Blue Cross has the following standard contract exclusion:

Services or expenses any provider renders to a family member who is related to the provider by blood or marriage or who regularly resides in the provider's household are excluded from coverage under Blue Cross and Blue Shield of Alabama benefits. Examples of a provider include, but are not limited to, a physician, a licensed registered nurse, a licensed practical nurse, or a licensed physical therapist. Claims for services rendered to family members should not be filed to Blue Cross. If you are paid in error for a service that should be noncovered, use the Voluntary Overpayment Return Form to return the payment. A separate check for each adjustment to be made should be included with the form. If necessary, refunds will be requested on any services identified as being paid in error.

Practice Site Standards

Blue Cross' Practice Site Standards are for all credentialed practitioners providing ambulatory care to our members. These standards were developed to assure members have access to care in a clean, safe, organized and physically accessible environment. Please review the standards below and apply them to your practice.

Office Standards

- Identifiable office signage
- Adequate parking with handicap access
- Building accommodations for handicapped individuals
- Examination rooms designed for patient privacy
- Adequate waiting room space
- Adequate lighting throughout facility
- No obstructions that might jeopardize patient safety
- Well-marked fire safety/emergency action plan with clear pathway to doors
- Visible processes for infection control and disposal of needles, sharps, medical wastes, etc.

Patient Health Information and Medical Record Standards

- Secure storage to protect patient confidentiality
- Documentation consistent with good medical/professional practices
- Meets standards for internal/external reviews and/or medical audits
- Facilitates appropriate treatment by another healthcare practitioner

Blue Cross' Quality Department will notify providers regarding member complaints received about practice site quality. Practices may be subject to an on-site evaluation and a corrective action plan, if warranted. Non-compliant practices will be referred to the Blue Cross Credentialing Committee for a decision on continued network status.

Services Performed in a School Setting

There has been an increased volume of services such as flu shots, eye exams and therapy performed in school settings. Schools are not a permissible place of service unless the member's benefits explicitly state otherwise or there is government funding available for these services.

Note: It is not appropriate to bill a patient's insurance for government-funded services.

Blue Cross contracted providers agree not to discriminate when providing healthcare services. Therefore, providers are not allowed to bill a patient with insurance differently than a patient without insurance. Refer to your network agreement for verbiage specific to your specialty.

Fee schedule amounts are determined using the site-of-service differential including cost of overhead. Therefore, reimbursement would not be accurate for services performed in a setting where there is no overhead cost.

Professional Courtesy Discounts

Professional courtesy may apply when a physician treats another physician or the physician's employees, healthcare providers, or family members of the physician's employees. When professional courtesy is extended, the fees for the physician treating the patient are usually made at a reduced rate, or the copayment may be waived. Professional courtesy does not apply when a physician is treating his own family members under most contracts.

The PMD Program does allow for certain discounts as professional courtesy as stated in Section 4.5 of the PMD contract. PMD physicians, except in cases of professional courtesy or inability to pay, will bill the patient for any applicable copayments or deductions. Such discounts should be documented in the patient chart with the reason for discount.

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Lucet is an independent company providing behavioral health services to Blue Cross and Blue Shield of Alabama members.

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