# Table of Contents

Introduction ........................................................................................................................................ 7
Discrimination Disclaimer ..................................................................................................................... 8
Getting in Touch with BCBSVT and TVHP .......................................................................................... 8
Office Training and Orientation: .......................................................................................................... 9
Member Rights and Responsibilities ................................................................................................. 9
Privacy Practices of BCBSVT .............................................................................................................. 10
Health Insurance Portability and Accountability Act (HIPAA) Responsibilities ..................................... 11
Contracting with BCBSVT .................................................................................................................. 13
Incentives for Participation ................................................................................................................ 13
Definition of Network Provider (Primary Care and Specialty Care): .................................................. 15
Requirements of Contracted/Credentialed/Enrolled Providers/Groups ........................................... 16
Provider Roles and Responsibilities .................................................................................................. 16
After-Hours Phone Coverage ........................................................................................................... 18
Accessibility of Services and Provider Administrative Service Standards ........................................ 19
The BCBSVT Quality ......................................................................................................................... 19
Reporting of Fraudulent Activity ....................................................................................................... 19
BCBSVT Audit .................................................................................................................................. 19
Provider Initiated Audit .................................................................................................................... 19
Availability of Network Practitioners ................................................................................................. 19
Opening/Closing/Moving of Primary Care Provider Patient Panels .................................................. 21
Primary Care Services ....................................................................................................................... 21
Provider Initiated Member Transfer .................................................................................................. 22
Transitioning Pediatric Patients ......................................................................................................... 22
Enrollment and Credentialing Requirements....................................................................................... 24
Providers’ Rights During the Credentialing Process: ...................................................................... Error! Bookmark not defined.
Facility Credentialing: .................................................................................................................... Error! Bookmark not defined.
Providers Without Internet Access .................................................................................................... 27
Provider Going on Sabbatical ............................................................................................................. 29
Notification of Change in Provider and/or Group Information (Demographic Information) ................ 30
Provider Going on Sabbatical ............................................................................................................. 31
Deleting/Terminating a Provider ....................................................................................................... 31
Industry Standard Diagnosis Codes ................................................................. 61
Claim Filing Limits .......................................................................................... 62
**New Claims** .............................................................................................. 62
Adjustments and Corrected Claims: .............................................................. 62
Interest Payments .......................................................................................... 62
Claim Submission when Contracting with More than One Blue Plan .............. 63
Use of Third-Party Billers/Vendors ................................................................. 63
Grace Period for Individuals through the Exchange ....................................... 64
Claims for dates of service during the first month of grace period: .................. 64
Claims for dates of service during the second and third month of the grace period 64
Audits and Overpayments ............................................................................ 64
Provider Requested Claim Review ............................................................... 66
Member Confidential Communications .......................................................... 67
Advantages to Electronic Claim Submission ................................................. 69
General Electronic Data Interchange (EDI) Claim Submission Information .... 69
  HIPAA-Compliant 837 Claim Submission (Electronic) .................................. 69
**HIPAA compliance:** .................................................................................. 69
Secondary Claim Submissions ........................................................................ 70
Paper Claim Submission ............................................................................... 71
How to Avoid Paper Claim Processing Delays .............................................. 72
Submitting Attachments with Claims ............................................................ 72
Frequent Issues with Paper Claim Submissions .......................................... 72
ClaimsXten-Select™ ..................................................................................... 74
**Exceptions to ClaimsXten-Select™ Logic:** ............................................... 74
Upgrades to ClaimsXten-Select™ Logic: ..................................................... 74
ClaimsXten-Select™ Logic Review: ............................................................... 74
Clear Claim Connection™ (C3) ..................................................................... 75
**Accuracy of the Results You Receive in C3:** ............................................ 76
Coordination of Benefits (COB) ................................................................. 78
Coordination of Benefits (COB) – Members with more than one BCBSVT Policy 78
Work-Related Injuries and COB ................................................................. 79
Exhausted Workers Compensation Benefits .......................................... 81
Medicare Supplemental and Secondary Claim Submission – Coordination of Benefits 82
Exclusions: .............................................................................................................................. 82
How COBA works .................................................................................................................. 82
Quick Tips ............................................................................................................................... 82
Special Billing Instructions for Rural Health Center or Federally Qualified Health Center .... 84
Claims Where Medicare Is Primary and an ICD-10-CM Manifestation Code Is Reported as the Primary Diagnosis ........................................................................................................ 84
BCBSVT Contracted Providers Not Participating with Medicare or Opting Out of Medicare 84
Claim Specific Guidelines ........................................................................................................ 87
What Is the BlueCard® Program? .......................................................................................... 136
Accounts Exempt from the BlueCard® Program .................................................................. 136
How to Identify Members ....................................................................................................... 137
Member ID Cards: .................................................................................................................. 137
Medicaid ID Cards: ............................................................................................................... 137
Identification Cards/Foreign Identification Cards: ............................................................... 137
Consumer Directed Health Care and Health Care Debit Cards ........................................... 138
Coverage and Eligibility Verification .................................................................................. 139
Utilization Review ............................................................................................................... 139
Claim Filing ........................................................................................................................... 140
How Claims Flow Through BlueCard® ............................................................................. 141
Medicare Advantage Overview ........................................................................................... 142
Types of Medicare Advantage Plans .................................................................................. 142
How to Recognize Medicare Advantage Members ................................................................ 143
Eligibility Verification: ......................................................................................................... 143
Medicare Advantage Claims Submission ............................................................................ 143
Traditional Medicare-Related Claims ................................................................................ 144
Providers in a Border County or Having Multiple Contracts ............................................. 145
International Claims ........................................................................................................... 145
Medical Records .................................................................................................................. 145
Adjustments/Corrected Claims ......................................................................................... 145
Returned Claim(s) Resubmission ....................................................................................... 146
Appeals ................................................................................................................................. 146
Coordination of Benefits Claims ........................................................................................ 146
The Federal Employee Program (FEP) ............................................................................... 149
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to FEP</td>
<td>149</td>
</tr>
<tr>
<td>Advantages to Providers</td>
<td>149</td>
</tr>
<tr>
<td>Member ID Cards</td>
<td>149</td>
</tr>
<tr>
<td>Sample ID Card:</td>
<td>150</td>
</tr>
<tr>
<td>Coverage and Eligibility Verification</td>
<td>150</td>
</tr>
<tr>
<td>Advanced Benefit Determinations</td>
<td>150</td>
</tr>
<tr>
<td>Prior Approval</td>
<td>151</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>151</td>
</tr>
<tr>
<td>Claim Filings</td>
<td>151</td>
</tr>
<tr>
<td>Dental Services</td>
<td>152</td>
</tr>
<tr>
<td>FEP BlueDental:</td>
<td>152</td>
</tr>
<tr>
<td>When a FEP member does not have Medicare B</td>
<td>152</td>
</tr>
<tr>
<td>Provider Voucher and 835 Transactions</td>
<td>153</td>
</tr>
<tr>
<td>General Electronic Data Interchange Remit Information:</td>
<td>153</td>
</tr>
<tr>
<td>HIPAA compliant 835 Electronic Remittance Advice (ERA)</td>
<td>153</td>
</tr>
<tr>
<td>Paper Provider Vouchers</td>
<td>154</td>
</tr>
<tr>
<td>Overview of a provider voucher</td>
<td>154</td>
</tr>
<tr>
<td>Information Contained on the Provider Voucher:</td>
<td>155</td>
</tr>
<tr>
<td>Frequently Asked Questions about the Paper Provider Voucher</td>
<td>159</td>
</tr>
</tbody>
</table>
Introduction

This handbook is designed to provide the details regarding Blue Cross and Blue Shield of Vermont (BCBSVT) – including New England Health Plan (NEHP), Access Blue New England (ABNE), BlueCard®, and Federal Employee Program (FEP).

More information may be added to this handbook periodically, and the information contained within the handbook may change. Notices related to changes in the handbook will be posted to the “What’s New” area of our provider website. Each new version of the provider handbook highlights the changes from the previous version in red font.
Section 1

General Information on BCBSVT

Discrimination Disclaimer

Section 1557 of the Affordable Care Act prohibits discrimination in health care on the basis of race, color, national origin, age, disability and sex (including gender identity and sexual orientation). Pursuant to this and other federal and state civil rights laws BCBSVT does not discriminate, exclude, or treat people differently because of these characteristics. These statements apply to our employees, customers, business partners, vendors and providers.

Getting in Touch with BCBSVT and TVHP

A customer service team specializing in provider issues is available to you by email or phone — please see the contact directory link below for. Email is generally responded to within three business days or the phone lines are open weekdays from 7 a.m. until 6 p.m. Please have the following information available when you email* or call:

- Your National Provider Identifier(s).
- Your patient’s name, identification number, including the alpha prefix, date of birth and date of service (if applicable)

*this is the recommended way to get your questions answered as our phones can be extremely busy and hold times can be lengthy. When emailing, please make sure you include all the information you would if calling the customer service team: billing NPI number, member name, member identification number, member date of birth and date(s) of service. Including this information in your initial email will reduce back and forth and overall response time. Please note, all emails sent by BCBSVT are secure and HIPAA compliant.

customerservice@bcbsvt.com for BCBSVT, New England Health Plan, Access Blue
fepcustomerservice@bcbsvt.com for Federal Employee Program
bluecard@bcbsvt.com for BlueCard
MedicareAdvantage@bcbsvt.com for MedicareAdvantage (non-Vermont Blue Advantage)- please note, only emails are accepted for these inquiries.
Office Training and Orientation:

Your provider relations consultant can assist you in several ways:

- Provider contracting information and interpretation
- On-site visits
- Provider and office staff education and training
- Information regarding BCBSVT policies, procedures, programs and services

Provider relations can be reached by email at providerrelations@bcbsvt.com or phone at (888) 449-0443 option 1.

Secure Messaging

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires our electronic communications that contain Protected Health Information (PHI) to be secure. To comply, we use the services of Proofpoint to protect our email and ensure all PHI remains confidential.

When a one of our employees sends you an email that contains PHI, Proofpoint detects the PHI and protects the email.

- You will receive an email notification that you have been sent a Proofpoint secure message.
- The notification tells you who the secure message is from and includes a link to retrieve the email message.
- The first time you use the Proofpoint message service to retrieve a message, you must create a password. Thereafter, you can use the same password each time you log into the Proofpoint Center to retrieve an encrypted BCBSVT/TVHP email.

**Note:** Proofpoint secure messages are posted and available for **30 calendar days**. If the message is not opened during that time, the message is removed, and the sender notified.

For more information about Proofpoint, visit: [https://securemail.bcbsvt.com/help/enus_encryption.htm](https://securemail.bcbsvt.com/help/enus_encryption.htm)

Member Rights and Responsibilities

Click here for full details
Privacy Practices of BCBSVT

We are required by law to maintain the privacy of our members’ health information by using or disclosing it only with the member’s authorization or as otherwise allowed by law. Members have the right to information about our privacy practices. A complete copy of our Notice of Privacy Practices is available at www.bcbsvt.com/privacyPolicies, or to request a copy, contact the provider relations team.
Section 1.1

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities

BCBSVT, TVHP, and its contracted providers are each individually considered “Covered Entities” under the Health Insurance Portability and Accountability Act Administrative Simplification Regulations (HIPAA-AS) issued by the U.S. Department of Health and Human Services (45 C.F.R. Parts 160-164). BCBSVT, TVHP and contracted providers shall, by the compliance date of each of the HIPAA-AS regulations, have implemented the necessary policies and procedures to comply.

For the purposes of this Section, the terms “Business Associate,” “Covered Entity,” “Health Care Operations,” “Payment,” and “Protected Health Information” have the same meaning as in 45 C.F.R. §§160 and 164.

Business Associates: Providers are required to provide us with written notice of the existence of any agreement with a Business Associate, including, but not limited to, a billing service* to which provider discloses Protected Health Information for the purposes of obtaining payment from BCBSVT and/or TVHP.

The notice to us regarding such agreement shall, at a minimum, include:

- The name of the Business Associate
- The address of the Business Associate
- The address to which BCBSVT and/or TVHP should remit payment (if different from the provider’s office)
- The contact person, if applicable

Upon receipt of notice, we will communicate directly with Business Associate regarding payment due to provider.

Provider must notify us of the termination of the Business Associate agreement in writing within ten business days of termination of the Business Associate agreement. BCBSVT/TVHP shall not be liable for payment remitted to Provider’s Business Associate prior to receipt of such notification. Notifications should be sent to:

[11]
Provider Handbook
Version 8.2 – August 1, 2021
Blue Cross and Blue Shield of Vermont  
Attn: Privacy Officer  
PO Box 186  
Montpelier, VT 05601-0186  

*See also section 6.1 Use of Third-Party Billers/Vendors for more specifics.

**Standard Transactions:** The provider and BCBSVT/TVHP shall exchange electronic transactions in the standard format required by HIPAA-AS. Questions regarding the status of HIPAA Transactions with us need to be directed to the E-Commerce Support Team at (800) 334-3441.
Section 1.2

BCBSVT/TVHP Contracts

Contracting with BCBSVT

All parties affiliated are responsible for the terms and conditions set forth in that contract.

In general, BCBSVT is limited to contracting with providers who provide services while physically located in Vermont or a county contiguous to Vermont. There are certain exceptions (for example, for durable medical equipment suppliers that ship materials to Vermont and independent clinical laboratories ordered by a Vermont physician), but BCBSVT may not contract with a provider physically located outside the state of Vermont (or a contiguous county) who is providing services via telemedicine only.

Entering into a contract with us covers the following products/members (dental practices may require additional contracts, see the Dental Section later on in this handbook for details):

- Accountable Blue
- Blue Cross and Blue Shield of Vermont members/products
- BlueCard (out-of-area) Program
- CBA Blue
- Federal Employee Program
- Medicare Advantage, including Vermont Blue Advantage
- Medicare Supplemental Insurance (Vermont Blue 65, formerly Medi-comp)
- The Vermont Health Plan
- Any other program bearing the BCBS service marks

Providers who are under contract with us, are “participating providers” or “in-network providers.” These providers submit claims directly to us and receive claim payments from.

Participating and network providers accept our allowed prices as payment in full for covered services and agree not to balance-bill members.

**Incentives for Participation:** Participation with us offers the following advantages:

- Direct payment for all covered services - offers predictable cash flow and minimizes collection activities and bad debt exposure.
- Claims are processed in a timely manner. We make available either electronic (PDF or HIPAA compliant 835 formats) or provider vouchers which detail payments, patient responsibilities, adjustments and/or denials.
- Free Electronic Payments
Please note: if you select electronic payments, you no longer receive a paper provider voucher. A PDF format provider voucher is available on our secure provider website to print or download, or the 835 transaction is also available.

- Members receiving services are provided with a Summary of Health Plan Payments (SOHPP) identifying payments, deductible, coinsurance and co-payment obligations, adjustments and denials. The member’s SOHPP explains the provider’s commitment to patients through participation with BCBSVT and TVHP.
- We have a dedicated Provider Relations team who can assist and educate providers and their staff on the claims submission process, policy directives, verification of the patient’s coverage and clarification of the subscribers and provider’s contracts.
- Online provider directory contains the name, gender, specialty, hospital and/or medical group affiliations, board certification, if the provider is accepting new patients, languages spoken by the provider and office locations of every eligible provider. More information regarding the marketing of providers, refer to Section 1.8.
- Providers and their staff are given information on policies, procedures, and programs through informational e-mails, mailings, newsletters, workshops and on-site visits by provider relations consultants.
- We accept electronically submitted claims in a HIPAA-compliant format.
- Participating providers have around-the-clock access to our secure Provider Resource Center which provides claims status information, and member eligibility.

Contract offers will be extended at the time a new enrollment is received.

Note:

- Durable Medical Equipment Suppliers have some limitations on contracting. Please contact the provider files staff via email at providerfiles@bcbsvt.com or by phone at (888) 449-0443 option 2 for full details.
- Independent Clinical Laboratories need to contract with our Laboratory Benefit Manager, Avalon. To imitative the contracting process, please contact Avalon via email at Avalon-providers@avalonhcs.com.

Termination of Contract

Our Quality Improvement policy, Provider Contract Termination policy is located on the provider website under Policies, Quality Improvement.
Section 1.3

Provider Definition

**Definition of Network Provider (Primary Care and Specialty Care):**

We define Primary Care Provider and Specialty Care Provider as the following:

*Primary Care Provider (PCP):*

Our Quality Improvement Policy: PCP Selection Criteria Policy provides the complete details of the selection criteria. The policy is located on the provider portal under Policies, then the Quality Improvement link.

Note: as of May 15, 2021 physician assistants can be considered primary care providers and carry a patient panel. Please refer to the Quality Improvement Policy: PCP Selection Criteria Policy provides the complete details of the selection criteria.

*Specialty Care Provider (SPC):*

A network provider who is not considered a primary care provider.
Section 1.4

Requirements of Contracted/Credentialed/Enrolled Providers/Groups

There are certain requirements that both Primary Care Providers (PCP) and Specialty Care (SPC) providers must meet. These requirements are defined in our contracts, provider handbook and our policies. Policies are located on the provider website at www.bcbsvt.com/provider/policies under the BCBSVT policies link.

Provider Roles and Responsibilities

Open Communication: We encourage open communication between providers and members regarding appropriate treatment alternatives. We do not penalize providers for discussing medically necessary or appropriate care with members.

- **Conscientious Objections to the Provision of Services:** Providers are expected to discuss with members any conscientious objections he or she has to providing services, counseling or referrals.

- **Follow-Up and Self-Care:** Providers must assure that members are informed of specific health care needs requiring follow-up and that members receive training in self-care and other measures they may take to promote their own health.

- **Coordination of Care and Communication:**
  - **PCP** - Members select Primary Care Providers (PCPs), who are then responsible for coordinating the member’s care. PCPs are responsible for requesting any information that is needed from other providers to ensure the member receives appropriate care.
  - **Specialist** - When a member is referred to a specialist or other provider, we require the specialist or provider to send a medical report for that visit to the PCP to ensure that the PCP is informed of the member’s status.
  
  - **Behavioral Health and Primary Care Provider Communication:** We have a template that can be used to facilitate the communication between behavioral health and primary care providers to assist in patient-care coordination for patients receiving mental health substance use disorder services. This template is available on our provider website under Provider Handbook & Reference
Guide, General Information, communication form for behavioral health and primary care providers.

Use of Non-Participating Providers: Our Payment Policy for the “Use of Non-Participating Providers,” is located on our non-secure provider website under Policies. This policy articulates our expectations regarding the use of non-participating providers and details how BCBSVT enforces the requirements outlined in providers’ contracts.

Confidentiality and Accuracy of Member Records: Refer to the Medical & Treatment Record Standard policy on the provider website under Policies, Quality Improvement link for full details.

Access to Facilities and Maintenance of Records for Audits: Refer to the Facility/Provider Audit, sampling and Extrapolation policy on the provider website under Policies, Quality Improvement link for full details.

Prior Approval/Pre-Notification & Pre-Certification/Advanced Benefit Determinations (Pre-Service Requests)

Full details, including lists of services and forms related to this are available on our provider website under the Prior Approval/Pre-Notification/Pre-Service Requests link.

- **Advanced Benefit Determinations:** Federal Employee Program (FEP) members are entitled to a BCBSVT review and response to “Advanced Benefit Determinations.” This allows members and providers to submit a request in writing asking for benefit availability for specific services and receive a written response on coverage. Refer to Section 4, Advanced Benefit Determination, for further information.

- **Pre-Notification & Pre-Certification:** Contracted facilities are financially responsible for securing pre-notification prior to a member’s admission to an inpatient facility or skilled nursing facility. This applies to all Blue Plan members.

  If pre-notification is not obtained the claim will be denied for lack of prior approval, below are the allowances if an inpatient stay is denied:

  - If the inpatient stay was due to an emergency situation (we have a claim with the ER visit), medical notes can be sent to customer service for review by our integrated health team
  - If the inpatient stay was elective, or following an observation stay (without ER):
    - If the reason for the stay relates to services that require prior approval, the inpatient claim can only be reviewed if the circumstances for not obtaining pre-notification meet the criteria described in the retrospective prior approval policy. In these cases, a prior approval request for the stay should be submitted advising it is retrospective and include medical notes.
    - If the reason for the stay relates to services that do not require prior approval, the inpatient stay can be reviewed by sending medical notes to customer service for review by our integrated health team.
      - Note: Inpatient stays that do not require prior approval can be appealed, however, providers are encouraged to submit for a review through
customer service within the designated timely filing period before being told to appeal.

• *Mental Health Substance Use Disorder stays have different allowances.

Prior Approval:

▪ Participating and network providers are financially responsible for securing prior approvals before services are rendered, even if a BCBSVT/TVHP policy is secondary to Medicare. There are some exceptions for Medicare Primary, please refer to details on the prior approval list.

▪ Participating and network providers can be held financially liable for the use of non-participating providers.

For more information on services requiring Prior Approval, please refer to Section 4. Services that deny for lack of prior approval do not qualify for an appeal.

Durable Medical Equipment Suppliers

Supplies mailed to BCBS members must have proof of delivery (and, if possible, proof of receipt) filed in the patient’s medical records and be available upon request. This practice helps in situations where BCBSVT has been billed for supplies, but the member indicates the supplies were never received. This practice also helps to avoid the wasteful shipment of unnecessary supplies to members. For claims where proof of delivery has not been secured and the member indicates the materials were never received or the member indicates a receipt of too many supplies, BCBSVT may recover and the member will not be held liable.

If a DME item is recalled the DME supplier must take the following steps:

▪ Facilitate repair or maintenance or provide loaner equipment without additional charge to Plan or member and

▪ Work with the manufacturer to secure a new or refurbished device or work with the manufacturer to secure reimbursement for supplying the member with a replacement device and

▪ Not bill BCBSVT or the member for repair or replacement

After-Hours Phone Coverage

Refer to the After-Hours Phone coverage policy on the provider website under Policies, Quality Improvement link for full details.

We require that primary care providers (i.e., internal medicine, general practice, family practice, pediatricians, naturopaths, and qualifying nurse practitioners and physician assistants) and OBGYNs provide 24-hour, seven day a week access to members by means of an on-call or referral system.

We monitor access to after-hours care through periodic audits. The plan places a call to providers’ offices to verify acceptable after-hours practices are in place. We will contact providers not in compliance and will work with them to develop plans of corrective action.
Accessibility of Services and Provider Administrative Service Standards

Refer to the Accessibility of Services and Provider Administrative Service Standards on the provider website under the Policies, Quality Improvement link for full details.

The BCBSVT Quality Improvement Policy, Accessibility of Services and Provider Administrative Service Standards provides the complete details on the definition, policy, methodology for analyzing practitioner performance and reporting.

Reporting of Fraudulent Activity

If you suspect fraudulent activity is occurring, you need to report it to the fraud hotline:

- BCBSVT members call (833) 225-3810 or email Fraud_Issues@bcbsvt.com
- Federal Employee Program members call (800) 337-8440 or email Fraud_Issues@bcbsvt.com

Calls and emails are confidential. Each outreach is investigated and tracked for an accurate outcome.

BCBSVT Audit

The complete Audit, Sampling and Extrapolation Policy is available on our provider website at www.bcbsvt.com under the BCBSVT Policies/Payment Policies link.

Provider Initiated Audit

Written notification needs to be sent to the assigned provider relations consultant 30 days prior to the audit being initiated. The provider relations consultant will contact the provider group and coordinate the details specific to completing the audit, such as when it will take place, the information required, and the required formatting of documents.

Availability of Network Practitioners

The BCBSVT Quality Improvement Policy, Availability of Network Practitioners provides the definition of the policy, including geographic access, performance goals, travel time specifications, number of practitioners, linguistic and cultural needs and preferences and how the program is monitored. The policy is located on the provider portal under Policies, Quality Improvement.

Continuity of Care

We support continuity of care. Standing referrals to specialists for members with life-threatening, degenerative, or disabling conditions are allowed. A specialist may act as a PCP for these members if the specialist is willing to contract as such with the us, accept our payment rates and adhere to our credentialing and performance requirements. A request for a specialist to act as his or her PCP must come from the patient, and our medical director must review and approve the request.

Providers may contact the customer service team to initiate a request for a standing referral.
A pregnant woman in her second or third trimester can continue with her current provider until completion of postpartum care, even if the provider is out of network, if the provider agrees to certain conditions.

A new member with life-threatening, disabling, or degenerative conditions with an ongoing course of treatment with an out-of-network provider may see this provider for 60 days after enrollment or until accepted by a new provider. Our medical director must review and approve the request.

DEFINITIONS

“Life threatening” means the disease or condition is likely to be the proximate cause of death.

“Disabling” means the disease or condition alters the individual’s ability to
• function in his or her occupation;
• control his or her activities of daily living; and/or
• function within society

“Degenerative” means the disease or condition is recognized in the medical literature for progressive deterioration of any body part, organ, or system.
Section 1.4a

Additional Requirements for Primary Care Providers

Opening/Closing/Moving of Primary Care Provider Patient Panels

**Primary Care Services**

**Opening of a Closed Physician Panel:** A PCP may open his or her patient panel by sending a completed Provider Enrollment/Change Form (PECF). If opening your patient panel, be sure to include the date you wish to open your panel, otherwise, we will use the date we received the form.

**Closing of an Open Physician Panel:** We require 60 days’ advanced notice to close a patient panel. You must submit a Provider Enrollment/Change Form. The effective date will be 60 days from our receipt of the form. We will send confirmation of our receipt of your request, including the effective date of the change. A PCP may not close his or her panel to our members unless the panel is closed to all new patients.

**PCPs with Closed Patient Panels:** It is the PCP’s responsibility to review the monthly capitation report. If a member appears as an addition and is not an existing patient, notify your provider relations consultant immediately. The notification should contain the member ID number and name. We will notify the member and ask him or her to select a new PCP.

If notification from the PCP does not occur within 30 days, the PCP will be expected to provide health care until the member is removed from the provider’s patient panel.

We will send confirmation to the provider that the member has been removed and the effective date.

**Moving of an existing Patient Panel:** When a PCP with an established patient panel moves to a new location or practice, it is our policy to move the members/patient with the individual primary care provider as long as there is no interruption in the provider’s availability to see the patients as an in-network provider*. If there is a period (even one day) where the PCP would not be able to see our patients as an in-network provider, we will either (1) keep members with the existing practice the PCP left if they have the ability to take on the patients or (2) move the members to a different PCP/practice who is open to new patients and able to take the members on.

*provider must be enrolled, credentialed and have a contract (or part of a vendor/group contract) approved by BCBSVT in place to be eligible.
Examples:

PCP leaves ABC practice on 12/10/19 and opens a private practice as of 12/11/19 (Provider established the private practice with BCBSVT and has approval as of 12/11/19), members are moved with the PCP.

PCP leaves ABC practice on 12/10/19 and opens a private practice as of 12/11/19, but is not yet approved by BCBSVT, members would remain at ABC practice or be moved to another PCP practice with an open panel who can take on the patients.

PCP leaves ABC practice on 12/10/19 and opens a private practice until 01/01/20 (private practice is established with BCBSVT), members would remain at ABC practice or be moved to another PCP practice with an open panel who can take on the patients.

**Provider-Initiated Member Transfer**

A PCP may request to remove a member from his or her practice due to:

- Repeated failure to pay co-payments, deductibles, or other out-of-pocket costs.
- Repeated missed scheduled appointments.
- Rude behavior or verbal abuse of office staff.
- Repeated and inappropriate requests for prior approval; or
- Irreconcilable deterioration of the physician/patient relationship.

The PCP must submit a written request to his or her provider relations consultant clearly defining the reason and documenting concerns regarding the deterioration of the patient/physician relationship, and any steps that have been taken to resolve this problem. If you do not have your specific consultants contact information it can be emailed to providerrelations@bcbsvt.com.

The provider relations consultant and the director of provider service will review each case, considering provider and member rights and responsibilities.

If the transfer is approved, we will send a letter to the member with a copy to the PCP. The member will be instructed to select a new PCP who is not in the current PCP’s office. The current PCP is expected to provide health care to the departing patient, as medically necessary, until the new PCP selection becomes effective.

If we do not approve the transfer, we send the PCP a letter of explanation.

**Transitioning Pediatric Patients**

We know that transitioning your pediatric patient to their future provider for adult care can be an emotional and sensitive issue. We offer the following advice and tools to assist you:

- **Talk with your patients** who are approaching adulthood about the need to select a PCP. Help them to take the next step by recommending several providers. You may even be able to provide some insight into who may be a good fit for them.
• **Use the “Find a Doctor” tool** to help you or your patient identify appropriate providers who are accepting new patients. To access the Find a Doctor tool, go to www.bcbsvt.com and select the Find a Doctor link. Once you accept the terms you can search by name, location, specialty or specific gender of provider.

• **Send a letter** to your patients with a list of PCPs accepting new patients. We offer a customizable letter you can use to help highlight the importance of selecting a new provider and walk the patient through the process. This template is available on our provider website at www.bcbsvt.com/provider.

• **Encourage the patient** to call the customer service number listed on the back of their identification card for assistance in adding the new PCP to their member profile. We also offer an online option they can use to update their PCP by logging into our secure member portal at www.bcbsvt.com.
Section 1.5

Enrollment of Providers

**Enrollment and Credentialing Requirements**

To enroll, the group or individual must hold a contract with BCBSVT/TVHP. Groups must enroll and credential individual providers who are associated with the group.

**Note:** Providers joining existing, contracted groups or individual providers entering into a contract with BCBSVT are not eligible to render services to any BCBSVT/TVHP (including the Federal Employee Program) until they are fully enrolled and approved by the credentialing committee.

**Enrolling a new Group or Provider (including Locum Tenens)**

Our provider website at [www.bcbsvt.com/provider](http://www.bcbsvt.com/provider) under the link Contracting, Enrollment, Credentialing & Demographic Changes, provides all the details of what is required to begin the enrollment process.

You have the option of submitting an enrollment by using our online enrollment tool or using a form you can print out and submit through email or fax.

If you do not have access to the internet, you can obtain the details and required forms by contacting the provider files team via email at providerfiles@bcbsvt.com or phone at (888) 449-0443 option 2.

In addition to enrollment, providers not already credentialed by BCBSVT will need to go through a credentialing process. See below.

**Enrollment Durable Medical Equipment (DME) – Additional documentation**

In addition to the standard documentation required with the group enrollment, DME supplier are required to supply proof of accreditation by one of the following bodies:

- Accreditation Commission for Health Care (ACHC)
- Community Health Accreditation Program (CHAP)
- The Compliance Team Inc. of Exemplary Providers (TCT)
- Healthcare Quality Association on Accreditation (HQAA)
- The Joint Commission (TJC)
- The Board for Orthotist/Prosthetist Certification (BOC)
- American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCs)
Please note to the extent you have separate accreditations and/or licenses for different locations covered by your contract with BCBSVT, you should submit copies of information for each location.

**Enrollment Home Infusion Therapy (HIT) – Additional documentation**

In addition to the standard documentation required with the group enrollment, HIT supplier are required to supply proof of license (retail pharmacy, VT) and proof of the following:

Proof of accreditation by one of the following bodies:
- Accreditation Commission for Health Care Inc. (ACHC)
- Community Health Accreditation Program (CHAP)
- The Joint Commission (TJC)

Proof of applicable registrations and certificates (including, but not limited to, Federal Drug Enforcement Agency (DEA) Certificate)

Proof the pharmacist holds a current, valid, and unrestricted Vermont license

Please note to the extent you have separate accreditations and/or licenses for different locations covered by your contract with BCBSVT, you should submit copies of information for each location.

**Enrollment Laboratories (independent clinical)**

We use a Laboratory Benefit Manager (LBM), Avalon for our independent laboratory network. To initiate the enrollment and contracting process, please contact Avalon-providers@avalonhcs.com.

**Enrollment for Non-Dispensing Pharmacist for Medication Therapy Management (MTM) Program – Additional Steps**

Email Provider Contracting at providercontracting@bcbsvt.com and copy in our Clinical Pharmacist, Rita Baglini at baglinir@bcbsvt.com.

Once you have done that, follow the instructions in “Enrolling a new Group or Provider (including Locum Tenans) earlier in this section, noting on the Provider Enrollment and Change Form in the comment field “MTM Pharmacist”.

[25]
Provider Handbook
Version 8.2 – August 1, 2021
Section 1.6

Credentialing of Providers

Credentialing - General

Our Quality Improvement Credentialing Policies: (1) Facility Credentialing (2) Practitioner Credentialing and/or (3) Ancillary Provider Credentialing define requirement, the process, credentialing and recredentialing criteria and rights and responsibilities. The policies are located in two areas of our website:

- https://www.bcbsvt.com/provider/contracting-enrollment-credentialing-and-demographic-changes under the Credentialing area or
- the provider portal under Policies, Quality Improvement

Initial Credentialing Process

The first step is to complete or update a Council for Affordable Quality Health care (CAQH) application. High level details are provided below, however, for complete detailed instructions, please refer to the “Provider Quick Reference Guide” on the CAQH website.

- Providers should use https://proview.caqh.org/pr to access their CAQH application.
- Practice managers should use https://proview.caqh.org/pm to access the provider’s CAQH application.

If you encounter any issue using the CAQH website or have questions, please contact the CAQH Provider Help Desk at (888) 599-1771.

Providers Currently Affiliated with CAQH:

- Log onto https://proview.caqh.org/pr using your CAQH ID number
- Re-attest the information submitted is true and accurate to the best of your knowledge. Please note that malpractice insurance information must be up to date and attached electronically. Also, practice locations need to be updated to indicate the group that the provider is being enrolled in.
- If you do not have a “global authorization”, you will need to assign BCBSVT as an authorized agent, allowing BCBSVT access to your credentialing information.
- If you encounter any difficulties uploading updated supporting information, documentation can be emailed to documents@proview.caqh.org and they will upload the information for you.
Providers Not Yet Affiliated with CAQH with Internet Access:

- CAQH has a self-registration process. If you are the provider, go to https://proview.caqh.org/pr. If you are a practice manager, go to https://proview.caqh.org/pm to complete an initial registration form. The form will require the provider/practice to enter identifying information, including an email address and NPI number.
- Once the initial registration form is completed and submitted, the provider/practice manager will immediately receive an email with a new CAQH provider ID.
- Login to CAQH with the ID and create a unique username and password. Complete the online credentialing application. Be sure to include copies of current medical license, malpractice insurance and, if applicable, Drug Enforcement Agency License.
- If you do not have a “global authorization,” you will need to assign BCBSVT as an authorized agent, allowing us access to your credentialing information.
- If a participating organization you wish to authorize does not appear, please contact that organization, and ask to be added to their provider roster.
- If you encounter any difficulties uploading updated supporting information, documentation can be emailed to documents@proview.caqh.org and they will upload the information for you.

Providers Not Yet Affiliated with CAQH and Without Internet Access:

Providers without Internet access must contact CAQH at (888) 599-1771 to request assistance with completing a CAQH profile. CAQH will assist with completing the application over the phone and then supporting documentation needs to be mailed to:

CAQH
P O Box 696537
San Antonio, TX 78269

You will want to request they assign BCBSVT as an authorized agent, allowing us access to your credentialing information. Or, you can request a “global authorization” that will allow all carrier access to your profile.

Once authorization has been given and your application is complete, CAQH will provide notification and Med Advantage will begin to process your application and primary source verify your credentialing information.

If for some reason your primary source verification exceeds 60 days, you will be notified in writing of the status and every 30 days thereafter, until the credentialing process is complete.

Upon completion of credentialing, you or your group practice will receive a confirmation of your assigned NPI, networks in which you are enrolled, and your effective date.

Quarterly Updates to your CAQH Profile
The Council for Affordable Quality Healthcare (CAQH) ProView profile requires you to update and/or attest every quarter. Information that may change and that you will want to update may include:

- Affiliations and Locations*
- License Number
- License State
- National Provider Identifier
- Board Certification(s)
- Place of Residency and Internship(s)
- Medical School
- Year of Graduation
- Specialties
- Liability Insurance

We use the CAQH DirectAssure provider directory validation solution. This allows us to ensure our provider directory information used by our members and providers is accurate and current. As a result, in addition to the usual information you must validate (above), there may be demographic validation (such as practice location, accepting new patients, etc.) that must be done.

Please note: CAQH DirectAssure requires practice managers to gain access to their provider accounts to make the necessary demographics updates. In the future DirectAssure is looking to roll out an enhanced practice manager system which will allow practice managers the ability to push directory demographics to a provider’s account without the need to log directly into a provider account.

Once you have confirmed or updated the information in CAQH, you must re-attest to the accuracy of the information.

*Reminder: The self-reported data in your CAQH ProView profile for demographic information or practice affiliation(s) has become the primary source we will use to validate our provider directory. When we find discrepancies between our provider directory and the CAQH ProView profile, we will use the CAQH ProView profile as the source of “truth” and update our directories and provider files accordingly.

Please keep your CAQH ProView profile current and attested to its accuracy quarterly. This is very important as we are relying on CAQH ProView information and will not be outreaching to you to verify what information is correct.

ALL practices and the various location(s) you work at need to be listed, even if the locations are not your primary location. Think of it as anywhere you have the potential to care for a patient should be listed.
Example: Dr. Smith is employed by ABC Family Practice. ABC Family Practice has several locations: 1 Main Street, Suite 2, 1 Main Street, Suite 5 (same medical complex but different locations), and 15 Second Street. Dr. Smith sees patients at all ABC Family Practice locations. In addition, he works at a XYZ Urgent Care on the weekends and sometimes does emergency room care at his local hospital.

In this example ABC Family Practice should be listed with the three locations, XYZ Urgent Care should be listed (with their address) and the local hospital (with their address) should also be listed.

Once you have made the updates, make sure to attest to your CAQH ProView Profile. Click “attest” once you confirm that the status bar at the top of your profile, “Profile Data”, shows the word “Complete” in green.

Please note, if you add a provider affiliation to CAQH ProView Profile, you will need to submit a Provider Enrollment and Change Form to add it to the existing group contract. Within CAQH ProView we are only terminating group affiliations that no longer exist.

If you have questions related to the CAQH website or functionality, please call the CAQH Provider Help Desk at (888) 599-1771.

Re-Credentialing of Providers

BCBSVT re-credentials providers every three-year following their initial credentialing date.

Advanced notice of re-credentialing is sent. You will need to make sure your CAQH profile is updated and attested to.

Re-credentialing approval letters are sent to providers and facilities upon request.

Re-credentialing denial letter are sent within sixty days of the decision date.

Primary Source Verification – Med Advantage

Our credentialing committee primary source verification is completed by our agent, the National Credentialing Verification Organization (NCVO) of Med Advantage.

Break in Credentialing

If a provider does not complete a timely re-credential or has a break in credentialing (for situations such as change of employment with more than a 30-day break), a full credentialing process has to be initiated. This process can take up to 90 business days.

Provider Going on Sabbatical

See section 1.7 for full details.
Section 1.7

Demographic and Provider Changes in an existing Provider Group

Notification of Change in Provider and/or Group Information (Demographic Information)

Please also see “Quarterly Updates of your CAQH Profile” for details on how your CAQH profile impacts your BCBSVT demographic information.

You must complete appropriate paperwork when you have a change in practice. Not keeping your information up to date can impact members, claims and your practice.

Reminder: Blueprint Patient-Centered Medical Homes (existing or new) need to inform BCBSVT of provider changes. The Blueprint Payment Roster Template is not our source of record for these changes.

Changes include but are not limited to:

Providers:

- Patient panel change (for primary care providers only)
- Physical, mailing or correspondence address
- Termination of a provider. In place of a PECF, we will accept an email for termination of a provider. Please see details below in “Deleting/Terminating a Provider” section.
- Provider name (include copy of new license with new name)
- Provider specialty
- Change in rendering national provider identification number

Provider Groups:

- Tax identification number (include updated W-9)
- Billing national provider identifier
- Physical, mailing and/or correspondence address
- Group name

Our provider website at www.bcbsvt.com/provider under the link Contracting, Enrollment, Credentialing & Demographic Changes, provides all the details.

You have the option of submitting these changes by using our online enrollment tool or using a form you can print out and submit through email or fax.
If you do not have access to the internet, you can obtain the details and required forms by contacting the provider files team via email at providerfiles@bcbsvt.com or phone at (888) 449-0443 option 2.

If you have a change that is not on the list above, please provide written notification on practice letterhead. Include the full names and NPI numbers for the group and all providers affected by the change.

We cannot accept requests for changes by telephone.

**Provider Going on Sabbatical**

Providers going on sabbatical for an indefinite time period need to suspend their network status. Notification needs to be sent to their assigned provider relations consultant and include the date when they are leaving and expected date of return. During the sabbatical time period, the provider will not be marketed in any directories and will have members temporarily reassigned to another BCBSVT contracted provider if a covering provider within their own practice is not identified.

Recredentialing will occur during the providers’ normal recredentialing cycle. The provider needs to make arrangements to ensure that the CAQH application and other information needed for recredentialing is available and timely. If recredentialing is not timely, the provider risks network termination.

**Deleting/Terminating a Provider**

A provider who leaves a group or private practice must provide advance notice to us. Notice can be provided via email to providerfiles@bcbsvt.com or by completing the “terminate provider” section of the Provider Enrollment and Change Form (PECF), either online or a paper form that is faxed or emailed.

If you are sending through email, be sure to include the provider’s full name; rendering national provider identifier (NPI), and if in a group setting, the NPI of the billing group; the reason for termination (such as moved out of state, went to another practice, going into private practice, etc.) and the termination date. If the terminating provider is a primary care provider, we will need to know if there is another provider taking on those patients. If submitting an electronic or paper PECF follow the instructions on the form.

We appreciate your help in keeping our records up to date. Notifying us in a timely manner of provider termination ensures access and continuity of care for BCBSVT/TVHP members.

BCBSVT notifies affected members of a provider termination 30 days in advance of the effective date of termination.

You can download a Provider Enrollment/Change Form by logging onto our provider site at www.bcbsvt.com. If you do not have internet access, please contact your provider relations consultant for a copy of the form.

Please also see “Quarterly Updates of your CAQH Profile” for details on how your CAQH profile impacts group affiliation.

**Taxonomy Updates**
Upon initial enrollment, if a taxonomy is indicated on the enrollment form, the taxonomy is added to our system. If there is no taxonomy reported on the enrollment, we use the reported taxonomy on file at the National Plan and Provider Enumeration System (NPPES).

Some claims require the reporting of a taxonomy code. However, if a taxonomy code is not required but reported, it is edited against. If it does not align with what we have on file, the claim will deny.

To update your taxonomy, you will want to:

- Update NPPES and notify us (providerfiles@bcbsvt.com or phone at (888) 449-0443 option 2) so we can update our system or
- Change you billing taxonomy to align with what we have on file and submit a corrected claim indicating the correct taxonomy
Section 1.8

BCBSVT Marketing of Providers in Member Directories

Online Provider Directory

This online tool is utilized by BCBSVT, FEP and BlueCard members to review important information about your providers.

Most* enrolled, contracted and credentialed providers are marketed in our on line provider directories, located on our website at www.bcbsvt.com under the Find a Doctor tool.

*There are a few exceptions that are noted below:

- Providers who practice exclusively within the facility or free-standing settings and who provide care for BCBSVT members only as a result of members being directed to a hospital or a facility.
- Dentists who provide primary dental care only under a dental plan or rider
- Covering providers (e.g., locum tenens)
- Providers who do not provide care for members in a treatment setting (e.g., board-certified consultants)
- Providers on sabbatical

The following provider information is supplied in the directories:
Name, including both first and last name of the physician or provider

Gender

Specialty determined based on education and training, and when applicable, certifications held during the credentialing process. Providers may request to be listed in multiple specialties if their education and training demonstrates competence in each area of practice. Approved lists of specialties and certificate categories from one of the below entities are accepted:

- American Board of Medical Specialties: [www.abms.org](http://www.abms.org)
- American Midwifery Certification Board: [www.amebmidwife.org](http://www.amebmidwife.org)
- American Nurses Association: [www.ana.org](http://www.ana.org)
- American Osteopathic Association: [www.osteopathic.org](http://www.osteopathic.org)
- The Royal College of Pathologists: [www.rcpath.org](http://www.rcpath.org)
- The Royal College of Physicians: [www.rcplondon.ac.uk](http://www.rcplondon.ac.uk)
- The College of Family Physicians of Canada: [www.cfpc.ca](http://www.cfpc.ca)

Hospital affiliations, admitting/attending privileges at listed hospitals

Board certification, including a list of board certification categories as reported by the ABMS

Medical Group Affiliations, including a list of all medical groups with which the physician is affiliated

Acceptance of new patients

Languages spoken by the physician

Office location, including physical address and phone number of office locations

NOTE: If a provider is rendering service by telemedicine only a physical address is not listed. Instead there is a note “call to schedule services.”

**Practice Name listed in Online Provider Directory**

The name reported on the first line of the W-9 submitted to us is the name we display in our on-line provider directory.

**BCBSVT Maintenance of the online Provider Directory using CAQH ProView**

The self-reported data in your CAQH ProView profile for demographic information is the primary source used to validate our provider directory. When we find discrepancies between our data and the CAQH ProView profile, we will use the CAQH ProView profile as the source of “truth” and update our directories and provider files accordingly.

**Maintenance of the online Provider Directory**

Any demographic changes submitted to us by providers/practices will be reflected in the online provider directory (see section on Demographic Changes for specifics).

However, you should periodically review and, if appropriate, update the information listed in our on-line provider directories located at [www.bcbsvt.com](http://www.bcbsvt.com), Find a Doctor tool. This tool provides our members (your patients) with important information about your providers and you want to make sure it is accurate.

When reviewing the information in the on-line provider directory make sure to check:
• Provider’s full name
• Whether you are accepting new patients or any patient panel limitations
• Location Information, including the physical location(s) you are available to see a patient.

Please note:
  • If you have more than one physical location, you will be listed in the directory for each location.
  • If your practice does not have a physical location(s) and services are provided to members by telemedicine or home visits, your physical location(s) information is not listed.

• Phone Number patients should call to schedule an appointment with you.
• Medical Group Affiliations, including the name of the practice where you work, if you do not have a private practice.
• Hospital Affiliations, including verification that the affiliation(s) listed are correct for the individual provider. Affiliation is defined as the network hospitals where the provider may provide services or send patients for care.

If any of the information is incorrect, please submit a provider enrollment change form (either online or paper submission via fax or email) identifying the change to our provider files team. Details on the process and forms are available at http://www.bcbsvt.com/provider/contracting.
Section 1.9

Reimbursement

Reimbursement Types

We reimburse professional billing providers in one of two ways:

1. **Fee for Service**: reimbursement for a service rendered, an amount paid to a provider based on our allowed price for the procedure code billed.

2. **Capitation**: a set amount of money paid to a Primary Care Provider. The amount is expressed in units of per member per month (PMPM). It varies according to factors such as age and sex of the enrolled members.

A capitated detail report, listing each member assigned to a PCP, the capitation rate being paid and general information about the member is generated by the 20th of each month. The report is posted to the Provider Resource Center (secure area for providers), under the Remittance Advice link.

Additional information on Capitation:

- providers not signed up for electronic funds have a paper copy of the capitation report mailed with their capitation payment. Providers that receive electronic funds have capitated reports posted to the Provider Resource Center under the remittance advice link.
- Capitation is paid during the three-month grace period for individuals covered through the Exchange (prefix ZII). If the member is terminated at the end of the grace period, months two and three will be recovered. For full details on grace periods, see “Grace Period for Individuals through the Exchange” in Section 6.
- Retroactivity for capitated payments is up to 90 days.
- Members that are within their deductible period are responsible for the liabilities reported on the provider voucher/835, even if the claim reports the capitated payment processing in addition to the members liabilities.

Notes on Reimbursement Types:

- Facility reimbursement uses different reimbursement methods.
- Our claim system processes claims containing mixed reimbursements (capitated and fee for service) as two separate claims. Claims are automatically broken out; one claim is generated for the services that receive the capitated reimbursement and the other claim is for the services that reimburse as fee for service. The claims may not process on the same provider voucher.
For claim number assignment in our system, the two claims receive the same claim number, however, the claim that has the capitated reimbursements adds a 5 after the Julian date.

Example:
- fee for service claim: 2619XXXXXXXXX
- capitated: 26195XXXXXXXXX

Both claims (the capitated and fee for service reimbursement) are reported to the provider voucher but in separate areas.

The 835 combines both claims (capitated and fee for service reimbursements) back into one claim and reports accordingly.

When a member is within their deductible period, they are liable for any amounts reported as a member liability attributed to deductible on the 835 or provider voucher. The claim will report as a capitated claim, with zero payment but the member liability noted. You will still receive your monthly PMPM capitation payment.

Reimbursement Methods

There are two ways to be reimbursed by BCBSVT:

- **Electronic Payments** are the preferred method of payment and offered to BCBSVT providers free of charge. Electronic payment offers the following benefits:
  - Reduces your practice administrative costs
  - Improves your cash flow; and
  - Makes transactions more secure and safer than paper checks

For full details and to sign up for Electronic Payments, go to our provider website [www.bcbsvt.com/provider](http://www.bcbsvt.com/provider) under the Electronic Payment link.

The Electronic Payments are sent in a CCD+ format. The CCD+ format is a National Automated Clearing House Association (NACHA) ACH corporate payment format with a single 80-character addendum record capability. The addendum record is used by BCBSVT to provide the EFT transaction number that ties back to the provider voucher/835’s.

- Provider Voucher – reports the transaction number on the first page under the “Reference Number” box directly below the Provider Number box.
- 835 – reports the transaction number in the TRN02 segment.

NOTE: If you are not receiving the addendum information with the EFT transaction number, you may need to outreach to your bank. Although banks receive this information, not all post it or forward it on.

Electronic payments are issued by Wells Fargo Bank

- **Paper Check**: Providers, upon effective date of contract, are automatically set up to receive paper provider vouchers and checks that are mailed using the US postal system.
Holiday’s do not impact our provider payment schedule, claims are finalized and moved to payment process on Tuesday of every week. Provider vouchers/835’s are available on Wednesdays and electronic payments are issued on Friday. If you receive a paper check, it is mailed on Wednesday of every week.

**Reimbursement Terms**

Payments for BCBSVT are limited to the amount specified in the provider’s contract with BCBSVT, less any copayments, coinsurance or deductibles, in accordance with the member’s benefit program.

**Billing of Members/Balance Billing Requirements**

For information related to Billing of Members/Balance Billing Requirements see Section 6.
Section 2

BCBSVT Provider Website and the Provider Resource Center (PRC)

The BCBSVT website located at www.bcbsvt.com/provider uses 128-bit encryption as well as firewalls with built-in intrusion detection software. In addition, we maintain security logs that include security events and administrative activity. These logs are reviewed daily.

Our provider website has a general area that anyone can access and a secure area, the Provider Resource Center (PRC), that only registered users can access.

The general area of the provider website contains information about doing business with us, such as recent provider mailings, news, forms, medical policies, provider handbook, tools and resources.

The secure area of the provider website (often referred to as the provider resource center) bcbsvt.com/prc contains information such as eligibility, benefits and claim status for BCBSVT, FEP and BlueCard members.

To become a registered user, you will need to work with your local administrator (this is a person in your organization who has already agreed to oversee the activities related to adding/deleting staff and assigning roles and responsibilities for your organization). If your organization does not already have a local administrator, click on the secure area of the provider website and follow the instructions to register as a new user.

Becoming a registered user is very important as callers with a claim status question that have not checked the PRC, may be re-directed to the PRC for self-service.

We have a Provider Resource Center Reference Guide available on our website at www.bcbsvt.com/provider under the link “Provider Handbook & Reference Guides.” This guide provides information on how to create an account, maintain users, and use the eligibility, claim look-up, ClearClaim Connect and online prior approval functionality.

Questions related to the website can be directed to the provider relations team.
Section 3

BCBSVT Member Information

This area is under development.
Section 4

Integrated Health Functions

Medical Utilization Management (Care Management)

Our integrated health department performs focused medical utilization review for selected inpatient and outpatient services. Medical utilization management is part of our overall care management program.

The focused inpatient utilization is based on an analysis of the individual hospital’s utilization and practice patterns and may vary by provider. Utilization patterns at the network hospitals are reviewed quarterly. As utilization patterns change, we evolve the focus of the inpatient utilization review process. Clinicians conduct telephonic review on those inpatient cases that meet the focus criteria for that quarter.

Integrated health staff also review targeted outpatient procedures and services through the prior approval process.

Clinicians are authorized to grant approval for services that meet plan guidelines, and deny services excluded from the benefit plan. A plan physician makes all denial decisions that require an evaluation of medical necessity.

Components of the medical utilization management program include:

- Pre-notification of admissions
- Prior approval/Pre-service
- Concurrent review
- Retrospective review/Post-service
- Discharge planning in collaboration with facilities, members and providers
- Medical claim review

We provide members, providers and facilities access to a toll-free number for utilization management review. The utilization management staff of the integrated health department is available to receive and place calls during normal business hours (8 a.m. to 4:30 p.m., Monday through Friday). Integrated health management staff do not place outgoing calls after normal business hours. In addition, members and/or providers who need to contact us after normal business hours may utilize the toll-free number and leave a voice message related to non-urgent/non-emergent care. Information may also be sent via fax or our provider website (www.bcbsvt.com/provider) at any time. (The website allows for clinical information to be attached with the request.) All inquiries received after hours are addressed the next business day.
For urgent or emergent care, a clinician and physician are available to providers (by toll-free telephone number) 24 hours a day, seven days a week, to render utilization review determinations. When speaking with others, the integrated health staff identify themselves by name, title and as an employee of BCBSVT. All inquiries related to specific UM cases are forwarded to integrated health staff for resolution, regardless of where the initial inquiry was received within the Plan.

Case managers collect data on all case-managed cases, including the following:

- Age of member
- Previous medical history and diagnosis
- Signs and symptoms of their illness and co-morbidities
- Diagnostic testing
- The current plan of care
- Family support and community resources
- Psychosocial needs
- Home care needs if appropriate
- Post-hospitalization medical support needs, including durable medical equipment, special therapy, and medications/infusion therapy

The following information sources are considered when clinicians perform utilization management review:

- Primary care provider and/or attending physician
- Member and/or family
- Hospital medical record
- Milliman Health Care Management Guidelines, Inpatient and Surgical Care and Ambulatory, and Recovery Facility Guidelines
- Blue Cross Blue Shield of Vermont medical policies
- Blue Cross Blue Shield Association medical policies
- Board-certified specialist consultants
- TEC (Technology Evaluation Center) assessment
- Health care providers involved in the member’s care
- Hospital clinical staff in the utilization and quality assurance departments
- Plan medical director and physician reviewers

A more intensive review occurs for some requested procedure/service(s) based on the need to direct care to specific providers, coverage issues, or based on quality concerns about the medical necessity for the requested procedure/service(s). A more intensive review may require office records and/or additional medical information to support the request. The services which require additional medical information include, but are not limited to:

- Possible cosmetic procedures, e.g. breast reduction
- Organ transplants
- Out-of-network for point of service product(s) and managed products
Individual member needs and circumstances are always considered when making UM decisions and are given the greatest weight if they conflict with utilization management guidelines. In addition, both behavioral and medical staff consider the capability of the Vermont health care system to actually deliver health services in an alternate (lesser) setting when applying utilization management criteria. If the requested services do not meet the Plan’s criteria, clinical staff documents the member’s clinical needs and circumstances, and any limitations in the delivery system and forward that information to a medical director for a decision.

**Utilization Review Process:** The utilization review clinician may contact the facility utilization review staff and/or the attending provider to obtain the clinical information needed to approve services. However, if the utilization review clinician cannot obtain sufficient information to determine the medical necessity, appropriateness, efficacy, or efficiency of the service requested, and/or the review is unresolved for any other reason, the Plan’s clinical reviewer refers the case to a Plan provider reviewer.

The Plan’s provider reviewer considers the individual clinical circumstances and the capabilities of the Vermont community delivery system for each case. In making the final determination, the actual clinical needs take precedence over published review criteria. In the event of an adverse decision, both the member and participating provider can request an appeal. The appeal procedure is documented more specifically later in this document.

During the concurrent review process, if services or treatments are provided to the member that were not included in the original request, and are determined to be not medically necessary, the Plan may deny those services or treatments and the member is not to be held liable. This means that the member is not penalized for care delivered prior to notification of an adverse determination. For further details see provider contracts.

Our utilization staff will not accept any financial incentive relating to UM decisions.

**Utilization Management Denial Notices: Reviewer Availability**

We notify providers of utilization management (UM) denials by letter. Providers are given the opportunity to discuss any utilization management (UM) denial decision with our physician or pharmacist reviewer.

All UM denial letters include the telephone number of our integrated health department. Providers may call this number if they want to discuss a UM denial with our physician or pharmacist. The telephone number is (800) 922-8778 (option 3) or (802) 371-3508.

**Clinical Practice Guidelines:** Our Quality Improvement Policy, Clinical Practice Guidelines provides the details on the policy, policy application and annual review criteria. The policy is located on the provider portal under Policies, then the Quality Improvement link.
Clinical Review Criteria: We utilize review guidelines that are informed by generally accepted medical and scientific evidence, and that are consistent with clinical practice parameters as recognized by health professionals in the specialties that typically provide the procedure or treatment, or diagnose or manage the medical condition. Such guidelines include nationally recognized health care guidelines, MCG, Level of Care utilization System (LOCUS), Child and Adolescent Level of Care Utilization (CALOCUS) and the American Society of Addiction Medicine (ASAM) criteria.

In addition to the national guidelines mentioned above, our internal medical policies and the Blue Cross Blue Shield Association Medical Policy and/or the TEC Assessment Publications are utilized as resources to reach decisions on matters of medical policy, benefit coverage and utilization management.

The Blue Cross Blue Shield Association Medical Policy Manual provides an informational resource which, along with other information, a member Blue Cross Blue Shield plan (and its licensed affiliates) may use to:

- Administer national accounts as they may decide to have their employee benefit coverage so interpreted.
- Assist the Plan in reaching its own decisions on matters of subscriber coverage and related medical policy, utilization management, managed care and quality assessment programs.

These guidelines are reviewed on an annual basis by the clinical advisory committee to assure relevance with current practice, taking into account input from practicing physicians, psychiatrists, and other health providers, including providers under contract with the Plan, if applicable, and are available to all providers under contract with the Plan, as well as to members and their treating providers upon request.

Providers and members may request a copy of the applicable criteria from the integrated health management department by facsimile (802) 371-3491, phone (800) 922-8778, option 1.

Clinical Practice Guidelines:

We have adopted the nationally recognized guidelines for the treatment of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Substance Use Disorders.

- Evaluation and Management of Congestive Heart Failure in the Adult, American College of Cardiology and American Heart Association: [www.cardiosource.org/](http://www.cardiosource.org/)

- The Plan has adopted nationally recognized preventive health and clinical practice guidelines for Adult and Pediatric Preventive Immunizations, Adult and Children and Adolescent Clinical Preventive Services, and treatment of Substance Abuse, Opioid Abuse, and Depressive Disorder. Nationally recognized experts developed these guidelines. The guidelines are available for you to read or print on the following websites:
• Adult Preventive Immunization, Centers for Disease Control and Prevention: www.cdc.gov/vaccines/schedules/hcp/adult.html
• Pediatric Preventive Immunizations, Centers for Disease Control and Prevention: www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html
• USPSTF Recommended Adult Preventive Guidelines and Preventive Guidelines for Children and Adolescents, U.S. Preventive Services Task Force: https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations
• Guidelines for the Treatment of Patients with Substance Abuse, Opioid Abuse, American Psychiatric Association: http://psychiatryonline.org/guidelines.aspx
• Guidelines for Treatment of Patients with Depressive Disorder, American Psychiatric Association: http://psychiatryonline.org/guidelines.aspx

In addition to the nationally recognized preventive health and clinical practice guidelines listed above, we bi-annually adopt new clinical practice guidelines and reviews clinical guidelines that we previously adopted. We adopted guidelines for the treatment of Chronic Heart Failure, Chronic Obstructive Pulmonary Disease, Diabetes, Asthma, Overweight and Obesity, and Hypertension. The guidelines may be evidence-based guidelines or consensus guidelines developed by providers. These guidelines are available at http://www.bcbsvt.com/provider/policies/clinical-practice-guides or by calling Customer Service at (800) 924-3494 or emailing customerservice@bcbsvt.com.

**Advanced Benefit Determination:** Federal Employee Program (FEP) members are entitled to “Advanced Benefit Determination”. This allows members and providers to submit a written request asking about benefit availability for specific services and receive a written response.

• You must use the prior approval form for submission of FEP advanced benefit determinations, but you will need to clearly mark the form (preferably at the top) “Advanced Benefit Determinations”.

• If the prior approval form is not clearly marked, it will be assumed you are submitting for prior approval only. A complete list of services requiring prior approval for FEP members is available on our provider website at www.bcbsvt.com/provider under the Prior Approval/Pre-Notification/Pre-Service request link.

**Prior Approval:** Prior approval is required for coverage of out of network (use of non-participating providers*), selected supplies, procedures, and pharmaceuticals before services are rendered, as outlined in member certificates and outlines of coverage. Even members with BCBSVT/TVHP as a secondary carrier, including those with Medicare as the primary carrier, need to obtain a prior approval for applicable services.

*BCBSVT has a payment policy for the Use of Non-Participating Providers which has certain requirements for BCBSVT contracted providers. If not met, there can be financial penalties applied. The complete policy is located on our non-secure provider website under Policies.
The BCBSVT prior approval list is updated quarterly. The FEP prior approval list is updated as of January 1 of every year. The current lists are available on the provider resource center located at www.bcbsvt.com.

Requests for prior approval can be submitted by fax or using the web-based authorization tool, Acuity Connect. Prior approval requests may be submitted by the referring provider*, the servicing provider or the member. Paper forms can be obtained from the provider resource center located at www.bcbsvt.com or by calling customer service.

*if prior approval is to an out of network provider/facility, the referring provider must submit the request for prior approval.

Prior approval requests are reviewed by our clinician, a medical director, a contract dentist reviewer, a pharmacist reviewer, or a Care Advantage Inc. (CAI) consultant medical director. The clinician may approve services but does not issue medical necessity denials. The dentist and pharmacist reviewers only review requests pertinent to their disciplines. Determinations to deny or limit services are only made by physicians under the direction of the medical director.

Upon receipt, the reviewer evaluates the prior approval request. If insufficient information is present for determination, additional information is requested, in writing, from the member or provider. The notice of extension specifically describes the required information and the deadline for return of the information to us. If no additional information is received by the stated deadline, we will deny the request for benefits as not medically necessary based on the information previously received, and the charges may be denied when claims are submitted without prior approval.

Once the information is sufficient for determination, the registered clinical reviewer approves requests that meet pre-established medical necessity criteria and are covered benefits. If medical necessity criteria are not met, the registered clinical reviewer refers the case to a medical director for decision. The physician reviewer may request additional information or contact the requesting physician directly to discuss the case. Appropriate clinical information is collected, and a decision formulated based on adherence to nationally accepted treatment guidelines and unique individual case features. References used to make determination include, but are not limited to:

- Blue Cross Blue Shield Association TEC Assessment
- Blue Cross Blue Shield Association Medical Policy Manual
- Blue Cross Blue Shield of Vermont Medical Policy Manual
- Medical director review of current scientific literature
- Review of specific professional medical and scientific organizations, (i.e. SAGES)
- Milliman Care Guidelines, Current Edition

Once a determination is made, the member, provider and the referred-to-provider are notified in writing for approvals and denials. Decision letters contain the following:

- A statement of the reviewers understanding of the request and
- If applicable, a description of any additional material or information necessary for the member to perfect the request and an explanation of why such material or information is necessary and
• If the review resulted in authorization, a clear and complete description of the service(s) that were authorized and all applicable limits or conditions and
• If the review resulted in adverse benefit determination, in whole or in part, the following is also included:
  o The specific reason for the adverse benefit determination, in easily understandable language
  o The text of the specific health benefit plan provisions on which the determination is based and
  o If the adverse benefit determination is based on medical necessity, an experimental/investigational exclusion, is otherwise an appealable decision or is otherwise a medically-based determination: an explanation of the scientific or clinical judgment for the determination, and an explanation of how the clinical review criteria and the terms of the health benefit plan apply to the member’s circumstances;
  o If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of such rule, guideline or protocol or other criterion will be provided to the member upon request and free of charge within two business days or, in the case of concurrent or urgent pre-service review, immediately upon request;
  o If the review is concurrent or pre-service, what, if any, alternative covered benefit(s) the Plan will consider to be medically necessary and would authorize if requested and
  o A description of grievance procedures and the time limits applicable to such procedures and
  o In the case of a concurrent review determination or an urgent, pre-service request, a description of the expedited grievance review process that may be applicable to such requests and
  o A description of the requirements and timeframes for filing grievances and/or a request for independent external review in order for the member or provider to be held harmless pending the outcome, where applicable and
  o Notice of the right to request independent external review after a grievance determination, in the language, format and manner prescribed by the Department; and
  o Local and toll-free numbers for the department’s health care consumer assistance section and the Vermont Office of Health Care Ombudsman.

For all lines of business, we adhere to Vermont Rule H2009-03, NCQA accreditation, and federal timeliness standards. For non-urgent pre-service review decisions, we must provide written notice of adverse determination to the member and treating provider (if known), within a reasonable period, not longer than two business days after receipt of the request. Verbal notification must be given to the member and treating provider (if known) with written notification sent within 24 hours of verbal notification.
If additional information is needed because of lack of information submitted with the prior approval request, we send a written request for additional information within two business days of receipt of the request. The notice of extension specifically describes the required information. The member or provider has at least 45 calendar days from receipt of the notice in which to provide the specified information.

We do not retroactively deny reimbursement for services that received prior approval, except in cases of fraud, including material misrepresentation. See provider contracts for more complete details.

Note:
- Dental prior approval for (1) Health Exchange pediatric members or (2) members of an administrative services only (ASO) whose employer group has purchased dental coverage through BCBSVT and are eligible through the BCBSVT Dental Medical policy “Part B” are reviewed by CBA Blue. See Dental Care in Section 6 for more details.
- Pharmacy prior approvals are reviewed by Optum Rx. However, not all members have pharmacy coverage through BCBSVT.
- Radiology prior approvals for BCBSVT members are reviewed by AIM Specialty Health. Radiology prior approvals for Federal Employee Program, New England Health Plan and Access Blue New England and reviewed by BCBSVT.

“Urgent” Prior Approval Requests: Please consider the following before marking a request as “urgent”

Per provider contracts:

Urgent services are those health care services that are necessary to treat a condition or illness of an individual that **if not treated within 24 hours** presents a serious risk of harm, or, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the ability of the individual to regain maximum function, or, in the opinion of a Physician with knowledge of the individuals medical condition, would subject the individual to severe pain that cannot be adequately managed without care within 24 hours.

- Marking a request as “urgent” does not guarantee immediate review; state guidelines permit us up to 48 hours to review a request marked as “urgent” (or one that is automatically treated as urgent under state rules).
- The most appropriate time to mark a request as “urgent” will be in situations involving urgently needed care (as defined by state regulations).
- We must respond to all prior approval requests within two business days, whether they are marked “urgent” or not.
- Please remember to submit requests **before** the member’s appointment.
- Please avoid submitting requests on a Friday unless necessary.
- Please ensure a request for prior approval is complete and contains required clinical information, as this will expedite the process.

**Prior Approval for Ambulance Services:** Refer to the current medical policy for Ambulance and Medical Transport Services to determine which service(s) require prior approval. We encourage the referring provider to obtain prior approval for ambulance/transport services.
Ambulance/transport providers do not generally contract with BCBSVT.

When a rendering provider is requesting a prior approval for ambulance/transport services, they need to know the ambulance service name, location, and national provider identifier. No coding is necessary. We use an ambulance transport service code.

We have two business days to review and make decisions on ambulance prior approval requests, unless they are marked urgent. Urgent requests have 48 hours to have a decision rendered. If you have enough time to file for prior approval before the transport, you should not mark the request as urgent.

**Special Notes Related to Prior Approval:**

- Home Health Agencies or Visiting Nurse Associations: a new authorization or an update/extension of an existing authorization does not need to be submitted or created should a member experience an inpatient admission during date spans for already approved services.
- If the inpatient stay results in the need to adjust the date span of already approved services or will result in services spanning a new calendar year, you need to contact our integrated health team at (800) 922-8778. We will adjust the existing authorization accordingly.

**Retrospective Review of Prior Approvals:** Prior Approval should always be secured prior to the service(s) being rendered. Contracted providers and facilities are held financially responsible if a prior approval is required and not obtained. Providers are not able to file an appeal for lack of prior approval. However, we will conduct a retrospective review for medical necessity when one of the applicable circumstances listed below occurs and the service was rendered without obtaining prior approval as required. The provider must contact us within a reasonable time, not to exceed 60 calendar days from the date of service, unless otherwise noted below.

**Ambulance Non-Emergent Transportation**

- All instances where prior approval was not requested before services were rendered.

**Chiropractic services:**

- Chiropractic services rendered within three (3) days of visit following visits 12th visit or any previously granted chiropractic treatment extension through the prior approval process (e.g. 18th, 24th, etc.)
- A claim denies for lack of Prior Approval, because the member’s benefit has been exhausted, but the provider took sufficient steps to verify benefits before providing the services to the member. Sufficient steps include verifying member benefits through a call to customer service or eligibility accumulator inquiry AND asking the member whether they have received other chiropractic care and receiving an answer from the member that the member has not received such care.

**Coverage unknown, changed or incorrect** – the 60 days starts from the date the provider was notified of the active coverage.

- Provider not aware member had BCBSVT coverage
- Provider not aware member had a change in BCBSVT coverage
- Provider advised member was not active through eligibility verification
• Provider received incorrect information about member’s coverage (eligibility, benefits or Medicare status)

**Change in Primary Insurance Processing** – the 60 days starts from the date of the other carrier’s reporting.

• Denial or recovery of primary insurer’s processing – Other carriers’ information must be included in the request for retrospective review.

**Discharge Planning**

• Discharge planning occurred during the Plan’s non-business operating hours

**Durable Medical Equipment (DME) Continuation** – continuation requests greater than 30 calendar days from the last covered authorization day will be reviewed for future services only and must include documentation supporting 60 days of member compliance.

• Continuation requests within 30 calendar days of the last covered day of the trial authorization for CPAP/BiPAP/TENS or any other continued DME

**Genetic Testing**

• Request received within 60 days of the specimen being collected and sent to the lab for processing

**Misquote**

• We quoted that a service, procedure, or supply did not require prior approval when it is on an applicable prior approval list and the retroactive request is received within 60 days from the first denial

**Physical, Speech or Occupational Therapy services**:

• A claim denies for lack of Prior Approval, but the provider took sufficient steps to verify benefits before providing the services to the member. Sufficient steps include verifying member benefits through a call to customer service or eligibility accumulator inquiry AND asking the member whether they have received other physical, speech or occupational therapy care and receiving an answer from the member that the member has not received such care.

**Treatment Plan Change**

- Provider requests a new or different procedure or service when a change in treatment plan is necessary during a procedure/service
- Provider determines, during a procedure/services, that additional services that require prior approval are needed
- Provider has an approved prior approval on file but determines, during a procedure/surgery, that a change in treatment plan is required and those additional services require prior approval
- Provider received approval for a specific code(s), but when the procedure was rendered the code(s) had changed by the National Coding Standards
Unable to Reach BCBSVT and/or Delegated Vendor Partners

- Provider attempted to obtain prior approval, but was unable to reach BCBSVT due to extenuating circumstances (natural disaster, power outage)

**Requesting a Retrospective Review:** If a provider identifies a service that qualifies for a retrospective review, he/she must submit a prior approval form noting it is a retrospective review and includes documentation that:

1. Supports the procedure provided, and
2. Provides details of why prior approval was not originally requested.

- We notify the provider of the outcome of the retrospective review within 30 days from receipt of request unless additional information is requested from the provider or it is not eligible for review.
Section 5

BCBSVT Programs and Standards

Quality Improvement

We have practice standards that are monitored as part of our quality program. These standards are posted to the provider website, under the Policies link:

- Accessibility of Service and Provider Administrative Standards
- Availability of Network Practitioners
- Clinical Practice Guidelines
- Credentialing Policy
- Enrollment of Non-Participating Practitioners
- Facility Credentialing Policy
- Medical and Treatment Record Standards
- PCP Selection Criteria
- Provider Appeals from Adverse Contract Actions and Denials of Participation in BCBSVT Networks
- Provider Contract Termination
- Quality of Care and Risk Investigations
- Site Visit and Medical Record Keep
- Supervised Practice of Mental Health & Substance Use Trainees
- Vermont Designated Agency

If you require a paper copy, please contact the provider relations team at providerrelations@bcbsvt.com or by phone at (888) 449-0443 option 1.

Feedback-Informed Treatment (FIT)

FIT is an empirically supported, pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from clients regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery.

BCBSVT and Vermont Collaborative Care (VCC) support the VT FIT Project through defraying the cost of the software license and the manuals, funding in training, and creating an enhanced reimbursement for those providers participating in the project. The project is part of a BCBSVT/VCC initiative to support the use of outcome measures and practice data for professional development and quality improvement. FIT is not associated with a specific type of psychotherapy; the measures are an enhancement to your
current practice. Data will not be used to limit the number of sessions allowed or to negatively affect reimbursement. No identifying patient data is accessible to BCBSVT or VCC through the online software.

For more information on the VT FIT project, please contact Kristin Fletcher at fletcherk@bcbsvt.com or phone at (802) 371-3231.
Section 6

Member Liabilities - How to Locate Information and When to Bill Members

Billing of Members/Balanced Billing Reminders

Covered Services: Contracted providers accept the fees specified in their contracts with BCBSVT as payment in full for covered services. Providers will not bill members, except for applicable copayments, coinsurance or deductibles.

We encourage providers to use their provider vouchers to determine member liability, for collection of deductibles and coinsurance, and to bill members.

Copayments, deductibles and coinsurance, however, can be billed to the member at the point of service, prior to rendering the service(s). In order to bill for these liabilities, providers must verify, either through the provider website or by calling customer service, the correct collection amount. Providers can bill members up to the allowed amount or member’s outstanding deductible balance, whichever is less.

For example:

- If the allowance is $80 and the member has a $60 outstanding balance to complete their deductible, you collect $60 from the member.
- If the allowance is $80 and the member has a $100 outstanding balance to complete their deductible, you collect $80 from the member.

If after receipt of the provider voucher the member liabilities are reduced, a quick turn-around in refunding the member any amounts due must occur.

Non-Covered Services: Member’s may be billed up front for non-covered services.

Member Liability Collection and/or Missed Appointment Policies: The provider must post, or the provider must communicate to patients the office policy on member liability collection and/or missed appointments. If a member does not comply with the requirements and there is a financial penalty, the member may be billed directly. A claim should not be submitted to us. Supporting documentation related to the incident needs to be noted in the member’s medical records.

Waivers: Services or items provided by a contracted/network provider that are considered by BCBSVT to be investigational, experimental or not medically necessary (as those terms are defined in the member’s certificate of coverage) may be billed to the patient if the following steps occur:

1. The provider has a reasonable belief that the service or item is investigational, experimental or
not medically necessary because: (a) our customer service or an eligibility request (using the secure provider web portal or a HIPAA-compliant 270 transaction) has confirmed that BCBSVT considers the service or item to be investigational, experimental or not medically necessary; or (b) BCBSVT has issued an adverse determination letter for a service or item requiring prior approval; or (c) the provider has been routinely notified by BCBSVT in the past that for members under similar circumstances, the services or items were considered investigational, experimental or not medically necessary.

2. Clear communication with the patient has occurred. This can be face-to-face or over the phone but must convey that the service will not be reimbursed by their insurance carrier and they will be held financially responsible. The complete cost of the service has been disclosed to the member along with any payment requirements; and

3. A waiver accepting financial liability for those services has been signed by the member and provider prior to the service being rendered. The waiver needs to clearly identify all costs that will be the responsibility of the member, once signed, the waiver must be placed in the member’s medical records.

4. Unless the member chooses otherwise, a claim for the service or item must be submitted to BCBSVT. This allows the member to have a record of processing for his/her files, and if he/she has an HSA or some type of health care spending account, to file a claim.

**Complaint and Grievance Process**

*Provider-on-Behalf-of-Member Appeal Process:* An appeal may only be filed by a provider on behalf of a member when there has been a denial of services which are benefit related for reasons such as: non-covered services pursuant to the Member Certificate; services are not medically necessary or investigational; lack of eligibility; or reduction of benefits (not a claim editing reduction).

Before a provider-on-behalf-of member appeal is submitted, we recommend you contact our customer service team, as most issues can be resolved without an appeal. If you proceed with an appeal, there are three levels to the Provider-on-behalf-of-Member Appeal process.

**Note:** Denials for lack of prior approval, duplicate, timely filing and claim edits (such as inclusive, mutually exclusive) cannot be appealed, per our provider contracts. Do not file appeals for these denials.

**Level 1—A First Level Provider-on-Behalf-of-Member Appeal:** A first level Provider-on-Behalf-of-Member Appeal must be filed within 180 days of the claim denial using one of the methods below:

- Fax – Attention Appeals (866) 617-8969
- Email – appeals@bcbsvt.com

**Note:** fax/email above are for appeals only. Benefits, claims or other questions will not be responded to if sent to this fax/email.

The appeal request should include all supporting clinical information along with the member certificate number, member name, date of service in question (if applicable), and the reason for appeal. (Please
Note that you need only submit supporting clinical information that has not been previously supplied to BCBSVT. All information submitted during prior approval or claim submission processes will be automatically included in the appeal.

Assuming you have provided all information necessary to decide your grievance, the appeal will be decided within the time frames shown below, based on the type of service that is the subject of your appeal (grievance):

- **Grievances related to “urgent concurrent” services (services that are part of an ongoing course of treatment involving urgent care and that have been approved by BCSVT) will be decided within twenty-four (24) hours of receipt;**
- **Grievances related to urgent services that have not yet been provided will be decided within seventy-two (72) hours of receipt;**
- **Grievances related to non-urgent mental health substance use disorder services and prescription drugs that have not yet been provided will be decided within seventy-two (72) hours of receipt;**
- **Grievances related to non-urgent services that have not yet been provided (other than mental health substance use disorder services and prescription drugs) will be decided within thirty (30) days of receipt; and**
- **Grievances related to services that have already been provided will be decided within sixty (60) days of receipt.**

If the Provider-on-Behalf-of-Member Appeal is urgent, as described above, you and the member will be notified by telephone and in writing of the outcome. If the appeal is not urgent, as described above, you and the member will be notified in writing of the outcome. If you are not satisfied with the first level Appeal decision, you may pursue the options below, if applicable.

**Level 2—Voluntary Second Level Appeal (not applicable to non-group):** A voluntary second-level appeal must be requested no later than ninety (90) days after receipt of our first-level denial notice. If we have denied your request to cover a health care service in whole or in part, as the provider on behalf of member, you may request a Voluntary Second Level Appeal at no cost to you or the member. Level one outlines the information that should be included with your appeal, review timeframes, and where the appeal should be sent. You and the member or the member’s authorized representative have the opportunity to participate in a telephone meeting or an in-person meeting with the reviewer(s) for your second level appeal, if you wish. If the scheduled meeting date does not work for you or the member, you may request that the meeting be postponed and rescheduled.

**Level 3—Independent External Appeal:** A provider on behalf of member may contact the External Appeals Program through the Vermont Department of Banking, Insurance, Securities and Health care Administration to submit an Independent External Appeal no later than one hundred twenty (120) days after receipt of our first level or voluntary second level (if applicable) denial notice. If you wish to extend coverage for ongoing treatment for urgent care services (“urgent concurrent” services) without interruption beyond what we have approved, you must request the review within twenty-four (24) hours after you receive our first level or voluntary second level denial notice. To make a request, contact the Vermont Department of Banking, Insurance, Securities and Health care Administration during business hours (7:45 a.m. to 4:30 p.m., EST, Monday through Friday) at External Appeals Program, Vermont Department of Banking, Insurance, Securities and Health care Administration, 89 Main Street,
Montpelier, VT 05620-3101, telephone: (800) 631-7788 (toll-free). If your request is urgent or an emergency, you may call twenty-four (24) hours a day, seven (7) days a week, including holidays. A recording will tell you how to reach the person on call. If your request is not urgent, the Department will provide you with a form to submit your request.

**BlueCard Member Claim Appeal:** An appeal request for a BlueCard member must be submitted in writing using the BlueCard Provider Claim Appeal Form located on the Provider Website under resources/forms/BlueCard Claim Appeal. If the form is not submitted, the request will not be considered an appeal. The request will not be filed with the home plan but rather returned to you. You will be informed of the decision in writing from BCBSVT. Please note, the form requires the member’s consent prior to submission. Some Blue Plans may also require the member to sign an additional form, specific to their Plan, before starting the appeal process.

**When a Member Has to Pay:** If a member’s appeal is denied, they must pay for non-covered services.

### Where to Find Co-payment Information

A co-payment is an amount that must be paid by the member for certain covered services. This amount is charged when services are rendered. The amount of the co-payment can be obtained by:

- Checking the front of the member’s identification card, or
- Using the eligibility look-up tool on the Provider Resource Center, or
- Referring to monthly membership reports (primary care providers only), or
- Contacting the customer service team

### When to Collect a Copayment

**Advanced Imaging:** Member liabilities (co-payment or deductible) are applied to the facility claim only.

Note: Administrative Services Only (ASO) groups may have different applications of member liabilities for advanced imaging.

**Mental Health Substance Use Disorder:** Our members have access to certain mental health and substance use services for the same co-payment as their primary care provider visit. A list of these services is available on our provider website at www.bcbsvt.com/provider under “Policies, Provider Handbook & Reference Guides,” then, “Mental Health Substance Use Disorder Co-payments.”

**Physician’s Office:** A co-payment is collected when an office visit service is rendered. Generally, co-payments are applied to the Evaluation and Management (E&M) services, which include office visits and exams performed in the physician’s office. Our reimbursement excludes the co-payment that the physician collects from the member.

If a member has two BCBSVT policies, the member is responsible for one co-payment; the policy with the lowest co-payment for the service will apply the co-payment. For example, if the primary BCBSVT policy has an office visit co-payment for $20 and the secondary BCBSVT policy has an office visit co-payment of $10, the member will only be responsible for the $10 co-payment.
Preventive Care: Most members have preventive benefits that either follow the federal guidelines of the Affordable Care Act (ACA) or are part of their “grandfathered” employer benefits or do not take a co-payment.

- Grandfathered preventive care follows the traditional BCBSVT preventive guidelines.
- ACA preventive has specific benefits that are defined in our online “Understanding Preventive Care” guide located at www.bcbsvt.com

To determine if a member has a “grandfathered” or ACA preventive benefit, verify a member’s eligibility by logging into the Provider Resource Center and using the eligibility tool, or call our customer service team at (800) 924-3494.

When verifying the member eligibility through the Provider Resource Center eligibility look up tool, scroll down to the bottom of the section “Benefit Plan Information.” Click on the “ADDITIONAL RIDER” link.

If one of the following riders appear after clicking on the link, the preventive benefits are grandfathered:

- BCBSVT Grandfathered Benefits Rider
- TVHP Grandfathered Benefits Rider

If a rider appears and has anywhere in the title “Preventive Care Rider,” the preventive benefit follows the federal benefit.

Telemedicine Services: A co-payment is collected when a telemedicine service is rendered. Generally, co-payments are applied to the Evaluation and Management (E&M) services. Our reimbursement excludes the co-payment that the physician collects from the member. Some members may have a different co-payment for telemedicine services.

Member Responsibility for Copayment

Members are expected to pay copayments at the time service is provided.

There may be situations where a provider does not want to collect a copayment (or deductible) from a member, or where the provider wishes to collect a lesser amount than that which is due under the terms of a member’s benefit program. However, the circumstances under which a provider may waive all or part of a copayment or deductible due from a member are limited. A provider may not waive a member’s copayment or deductible in an attempt to advertise or attract a member to that provider’s practice. A provider should limit waiver of copayments or deductible to situations where (1) the provider has a patient financial hardship policy (sometimes called a sliding-scale), and (2) the member in question meets the criteria for reduced or waived payment.

Third Party Payment of Premium:

BCBSVT has the discretion to reject payments, made by any means, directly or indirectly (i.e., making a check out to or otherwise paying the member to pay the amounts to BCBSVT) by third parties in accordance with applicable law. Payments of premiums by ineligible third parties have the potential to create conflicts of interest, skew the health coverage risk pool, and increase the risk of adverse
selection. This is detrimental to the long-term viability of the health coverage market overall and can result in increased rates for the entire market.

We will not accept premium payment from hospitals or providers.

We only accept premium and cost-sharing payments made by members or on behalf of members by the following:

- The Ryan White HIV/AIDS Program;
- Local, state, or federal government programs, including grantees directed by a government program to make payments on its behalf, that provide premium support for specific individuals;
- Indian tribes, tribal organizations/governments, and urban Indian organizations;
- The member’s family member
- Religious institutions and other not-for profit organizations when:
- The assistance is provided on the basis of the insured’s financial need;
- The institution or organization is not a healthcare provider; and
- The institution or organization is financially disinterested (i.e., the institution/organization does not receive funding from entities with a pecuniary interest in the payment of health insurance claims and/or benefits).

Members Responsibility for Payment When a Benefit Maximum is Met

Some benefits have plan year/calendar year limitations. When the benefit maximum is met for the members plan year/calendar year, members are responsible for the full charges up to the providers billed charge until the new plan year/calendar year begins. The provider voucher/835 will report the full billed charge due from the member.

For example: If a member has 30 physical therapy visits per calendar year and the 30-visit maximum is meet as of the last day of June, services received from July – December can be billed to the member at the provider billed amount. In January of the following year, the benefits will renew, assuming the member still has coverage, and member liabilities will only be up to the standard allowance.

You do not need to have a member sign a waiver. It would be appreciated if you learn they are near their maximum to remind them, so they are financially prepared to continue their care and not surprised when they get their bills.

You are not obligated to bill insurance once a benefit maximum is met, however, here are some things to consider:

- a vast majority of our members have flexible spending accounts, Health Savings Accounts or Health Reimbursement Accounts which cover certain medical expenses if they have no health insurance coverage available and for a member to be able to pull funds from those, will need the health insurance denial to do so.
• If you bill our processing will reflect you can bill the member up to the charged amount and the member explanation will say the same thing, so they will be aware you are no longer obligated to accept the BCBSVT allowance. I highly recommend continuing to bill for the services.
• If the member has some claims adjusted/recovered and now more benefits became available, it would process to the members benefits
Section 6.1

General Claim Information

Our mission is to process claims promptly and accurately. We generally issue a provider voucher or 835 for claims within 30 calendar days.

Submit all claims* to BCBSVT, following the BCBSVT paper claim submission or the 837 companion guidelines. These are available on our Provider Resource Center at bcbsvt.com/provider/electronic-business.

- Paper claims:
  - Fax to “Attention Claims Department” at (866) 334-4232 or
  - Email (make sure you send through a secure method) to claims@bcbsvt.com
- Electronic: Using a HIPAA-compliant 837 form to receive identification “BCBSVT.”

*For BlueCard® or FEP claims, please review the BlueCard® or FEP specific instructions provided in this handbook. Some exclusions apply.


To align with industry standards, we update the system set up for CPT and HCPCS codes on a quarterly basis (January, April, July and October). We complete a review of the new/revised codes and determine how we will implement these codes into our system (unit designation, modifiers, etc.) including the benefits (possible prior approval, investigational, preventive first dollar, etc.) provided for our members. (Note: Each Blue Plan determines their own benefits for services). We also remove the codes that are deleted.

- A notice is posted to the news area of our provider website at bcbsvt.com/provider/communications advising of any changes/additions in prior approval requirements, changes in unit designation, and any other information you should be aware of specific to the new/revised/deleted codes.
- The posting appears no later than at least two weeks prior to the effective date.

Not Elsewhere Classified (NEC) or Not Otherwise Classified (NOS) Codes: Providers should always bill a defined code when one is available. If one is not available, use an unlisted service (NEC or NOS), and provide a description of the service along with office and/or operative notes. The note must accompany the original claim. Please note, some of the NEC/NOS services may require prior approval. When this occurs, claims are not reviewed, and the claim processes based on status of prior approval. An example of this is compound drugs, such as J7999.

Industry Standard Diagnosis Codes: Diagnosis must be reported using Internal Classification of Disease 10th revision, Clinical Modification (ICD-10-CM). ICD-10 diagnosis codes are to be used and reported at
the highest number of characters available. We begin to use the newest release of ICD-10-CM on October 1 of each year.

Note:

- Providers should always bill a defined diagnosis code when one is available.
- We do not allow manifestation codes to be reported in the primary diagnosis field.

Please also refer to diagnosis-specific processing information later in this handbook.

**Claim Filing Limits**

**New Claims:**

- Must be submitted no later than 180 days from the date of service unless stated otherwise in the provider agreement.
- If another payer is primary, must be submitted 180 days from the date of the primary carrier’s processing.

Claims submitted after the expiration of the 180-day period will be denied for timely filing and cannot appealed or billed/collected from the member.

A provider/facility may request a review of timely filing denial within 90 days of the date on the provider voucher. The request can done be through one of these methods:

- Contacting the appropriate customer service team
- The submission of a Provider Inquiry Form, available on the provider website.

Supporting documentation should be included with the request. This documentation may include:

- The original claim number.
- A copy of the computerized printout of the patient account ledger, with the submission date identified.

Requests for review of untimely filing denials will be reviewed on a case-by-case basis. If the denial is upheld, a letter will be generated advising the provider of the outcome. If the denial is reversed, the claim will be processed for consideration on a future provider voucher.

**Adjustments and Corrected Claims:**

- Adjustments and corrected claims must be submitted within 180 days from the date of BCBSVT original payment or denial, unless stated otherwise in provider agreement.

**Interest Payments**

For qualifying claims, Vermont law (18 V.S.A. § 9418(e)) governs the payment of interest, based upon the amount paid by BCBSVT in accordance with Vermont law.
NOTE: Federal Employee Program claims are not subject to interest payments.

Claim Submission when Contracting with More than One Blue Plan

Providers who render services in contiguous counties or have secondary locations outside the State of Vermont may not always submit directly to BCBSVT. We have created three guides to assist you. They are located on our provider website at bcbsvt.com/provider/reference-guides. If you are an ancillary or remote provider refer to the section further on in this handbook.

Use of Third-Party Billers/Vendors

We define third-party billers (or vendors) as those entities/persons who are not physically located at a provider/group office, are not direct employees of the provider/group, and are submitting claims or following up on accounts on behalf of the provider/group and have a business associate relationship* with the provider/group. The provider/group must authorize third-party billers (or vendors) with us for information to be released. Below are the two methods by which third-party billers (or vendors) would access provider/group information and the steps the provider/group needs to take to grant access:

- For electronic access through the Provider Resource Center, the provider/group’s local administrator will need to grant access to the third-party biller (or vendor). Note: a third-party biller (or vendor) cannot be a local administrator for a provider/group. If a caller with a claims question has not checked the PRC, the caller maybe re-directed to the PRC for self-service.

- In order for a third-party biller (or vendor) to receive written correspondence from BCBSVT (such as notices, letters, or emails) or to obtain information via phone from our customer service team, the provider/group must submit written verification of (1) the name of the biller/vendor, (2) the names of the biller/vendor staff who will be calling, and (3) the phone number the biller/vendor will be calling from. These notifications must be sent to your provider relations consultant via email, fax or US Postal Service. You will receive a confirmation once the set-up is complete and the third-party biller (or vendor) has access.

Once a provider/group office has notified BCBSVT that the provider/group office uses a third-party biller (or vendor), the provider/group office must be prepared to disclose the identity of that third-party biller (or vendor) to BCBSVT’s customer service staff upon request if the provider/group office calls directly regarding the status of a claim.

*The provider/group should be prepared to produce proof of a business associate relationship with the biller/vendor upon request.

If you change your third-party biller (or vendor), you must notify your provider relations consultant immediately so access can be revoked.

Also see section 1.1 under Health Insurance Portability and Accountability Act (HIPPA) Responsibility of a Business Associate.
Grace Period for Individuals through the Exchange

Individuals enrolled through the State’s Health Exchange have very specific grace periods.

The federal Affordable Care Act requires that individuals receiving an advanced premium tax credit for the purchase of their health insurance be granted a three-month grace period for non-payment of premium before their membership is terminated.

BCBSVT administers the grace period as follows:

**Claims for dates of service during the first month of grace period:** We process the claims, make applicable payments and report through to a provider voucher. These payments are never recovered, even if the membership terminates at the end of the grace period. If you find later (and within 180 days of original processing) that you need to request an adjustment on one of these claims, simply submit following our standard guidelines, and the adjustment will process as usual. If additional money is due, it will be paid.

**Claims for dates of service during the second and third month of the grace period:** Claims are suspended. We alert you that the claim is suspended by letter sent through the US Postal Service to the payment address you have on file.

- If the premium is paid in full* at any point during month two or three of the grace period, the claim(s) are released for processing and reported through to a provider voucher.
- If the premium is not paid in full* prior to the end of the three-month grace period, the suspended claim(s) is denied through to a provider voucher and reported as “membership not on file,” reflecting the full billed amount as the member’s liability. The member also receives and summary of health plan payments with this information.

*Per the Affordable Care Act, when a member is within a grace period, they must pay all amounts due, up through their current billing period, to keep their insurance active.

Corrected claims (UB 04 bill types) or claim adjustments (UB04 or CMS 1500 types) for claims that are in month two or three of their grace period cannot be processed. They should not be submitted to us until after the claim has processed and reported to a provider voucher. If you happen to submit a corrected claim or adjustment, it will be returned directly to your office advising that the member is within their grace period, and that the correct claim or adjustment can be submitted after payment is made or termination is complete.

Audits and Overpayments

**Audit:**

It is our policy to collect any overpayments made to the provider in error.
When membership is terminated retroactively, we recover payments made for service provided after the termination date. Providers should then bill the member directly. Individuals who are covered through the Exchange have separate guidelines. For full details see “Grace period for Individuals through the Exchange.”

If we learn of other insurance or other party liability, we recover payments made for services.

We partner with Cotiviti Healthcare to provide reviews on coordination of benefit (COB) claims.

Cotiviti Healthcare looks at the following COB concepts:

- Active/inactive
- Automatic newborn coverage
- Birthday rule
- Dependent/non dependent
- Divorce decree
- Longer/shorter
- Medicare age: entitlement, disability entitlement, crossover, domestic partner, ESRD entitlement, home health, Part B only

We partner with Cotiviti Healthcare to provide reviews of the following for BlueCard®, FEP and BCBSVT/TVHP claims:

- Duplicate services
- Claims suspected to have administrative billing and payment errors
- Medically unlikely units (MUE)
- BCBSVT observation services payment policy
- BCBSVT provider-based billing payment policy

Most of the reviews are performed without any additional information from providers. They rely on the information contained on the claim(s), attachment(s) or information we have already collected.

Cotiviti Healthcare may outreach to your office directly to obtain more information. Please be advised that we do have a signed business associate agreement with Cotiviti Healthcare. You can release the requested information to them directly. Please make sure you do respond within the timeframe that is specified in the Cotiviti Healthcare request.

Change Healthcare performs quality assurance review of claim processing for:

- Coding Advisor Program – Frequent use of high-level service codes (e.g., 99205, 99215, etc)
- Facility billing (including DRG reimbursements)
- High cost injectable drugs
- Home infusion
- Renal dialysis

If you receive a request for information from Change Healthcare (or EquiClaim, as they still use that name at times) please make sure to respond promptly.

We also partner with Change Healthcare Solutions, LLC for a Coding Advisor Program. Change Healthcare reviews the use of high-level service codes (e.g., 99205-99215, etc.) for all provider types and
identified cases where providers are billing high-level codes with significantly greater frequency than other providers. Change Healthcare outreaches to provider who are outliers and provided education on coding.

Change Healthcare is a business associate of BCBSVT, so if you receive call or request for documentation form Change Healthcare, please provide a prompt response.

Overpayment:

When you detect an overpayment, please do not refund the overpayment amount to BCBSVT* or the patient. Instead, please complete a Provider Overpayment Form, which is available on the provider website. For an accurate adjustment, it is important to include all the information requested on the form. We will adjust the incorrectly processed claim by deducting from a future payment.

We prefer to recover, rather than accept funds from you, because:

- Claims history will simultaneously be corrected to accurately reflect the service and payment
- The provider voucher reflects the correction of the original claim
- Providers do not incur the expense of sending a check

*For BlueCard® claim refunds, if it is more than 24 months past the claim’s processing date, we may request a check directly from you because the refund must be done outside of the BlueCard® system. We will work with the member’s Blue Plan to have it credited accordingly.

We also have a partnership with CDR Associates for credit balance reviews. CDR performs onsite, retrospective provider credit balance reviews of all active BCBSVT accounts.

Focus of the CDR review:

- Duplicative and multiple payments
- Coordination of benefits/other liable insurance
- Payment in excess of contractual requirements
- Credit adjustment to charges

Provider Requested Claim Review

A claim review is a request by a provider for review of a claim that has been processed, when the provider is not in agreement with the processing and the claim cannot be appealed by the provider on behalf of the member. Reviews can be requested in circumstances such as:

- Concerns about the contract rate
- Amount of reimbursement
- Lack of prior approval*
- Duplicate service (for example, denial for duplicate services which the provider believes were clinically appropriate)

A claim review request may be made directly by contacting our customer service department or filed in writing using the Payment Inquiry Form. Claim Review requests must be made within 180 days of the
original provider voucher. All supporting documentation specific to the Claim Review must be supplied at the time of submission of the Payment Inquiry Form. The Claim Review request will be reviewed, and a letter of response provided pursuant to BCBSVT Policies.

*BlueCard® member benefits and prior approval requirements are administered by the member’s Blue Plan. We can initiate the claim review on your behalf.

**Member Confidential Communications**

Our members have the ability to file for a confidential communication process.

Facilities and/or providers working with members on this process need to have a strong process in place to notify their billing staff and place all claim submissions on hold until we have confirmed the process is complete and the claim(s) are ready to be submitted.

There are two types of confidential communication process:

- **Standard Confidential Communication**
- **Confidential Communication for Sexual Assault** (or other expedited matters).

**Standard Confidential Communication:**
The member uses a Form F14: Confidential Communication Request. A copy of the form is available on our website at [www.bcbsvt.com](http://www.bcbsvt.com).

Completed request forms for confidential communication must be faxed directly to the BCBSVT legal department secure fax line at (866) 529-8503 or mailed to the attention of the privacy officer, BCBSVT, PO Box 186, Montpelier, VT 05602 or faxed to our Customer Service department (802) 371-3658. The requests will be reviewed and processed within 30 days.

**Confidential Communication for Sexual Assault:**
At times, Vermont S.A.N.E. (sexual assault nurse examiners) help facilitate the confidential communication process for Vermont sexual assault crime victims. The nurse may submit the Vermont Center for Crime Victim Services confidential communication form or the BCBSVT confidential communication form.

These requests can be submitted using Form F14: Confidential Communication Request or the Vermont Center for Crime Victim Services Confidential Communication form. If you are using Form F14, please clearly note that it is related to sexual assault.

Forms must be faxed to the Legal Department (866) 529-8503 or the Customer Service department (802) 371-3658.

It is very important to include on the form or the fax cover sheet a contact person’s name and direct phone number for BCBSVT to follow up with questions or status on processing the request.
Confidential communications received for sexual assault cases are expedited because of the nature of the services and so that claims don’t get submitted and processed before BCBSVT gets the member’s Summary of Health Plan re-directed or member resource center access revoked.

For these expedited cases, the legal team will acknowledge receipt of the forms and inform the submitter that the setup is complete, and claims can be submitted.
Section 6.2

Electronic Claims – 837 transactions

Advantages to Electronic Claim Submission

- Reduced paperwork
- Savings on postage costs
- Reduced processing time

We encourage providers to submit claims electronically. Electronic Data Interchange/837 (professional or institutional) Companion Guides* are available on bcbsvt.com/provider on the electronic business page. If you have questions about electronic transaction requirements, please call Electronic Data Interchange (EDI) support at (800) 334-3441, option 2, or email us at editechsupport@bcbsvt.com.

*Updated Companion Guides are posted to the provider website on the electronic business page.

General Electronic Data Interchange (EDI) Claim Submission Information

We use several vendors/clearing houses to accept claims. All transactions received must be in an 837 HIPAA-compliant format. A list of clearing houses is available on bcbsvt.com/provider.

HIPAA-Compliant 837 Claim Submission (Electronic)

837 submitters submit 837 claim files to the BCBSVT secure SFTP site. BCBSVT will return EDI Acknowledgements (999/TA1) and HTML formatted EDI error reports.

Our provider website under the Electronic Data Interchange link provides the following Guides:

- SFTP User Guide
- 837 Professional Companion Guide
- 837 Institutional Companion Guide

HIPAA compliance: 837 file level vs. individual claim level rejections: Our Companion Guides indicate required elements, and in some cases, specific required values. We fully enforce these EDI HIPAA-compliant requirements. If any element fails, the entire 837 file is rejected.

Additional examples and information are provided in the Companion Guides.

Sample compliance examples:

- Provider NPIs (where the provider is required to enumerate) are required on the 837 per the HIPAA and NPI mandates.
• Required Elements should always be submitted with valid HIPAA values where applicable. Such as NM104 – patient first name should always be submitted when the person has a first name. 837 Institutional claims should include CL1 segment per the HIPAA implementation guide.

**Secondary Claim Submissions:** We support the Provider-to-Payer-to-Payer model as outlined in the HIPAA 5010 implementation. As a result, there is increased HIPAA compliance enforcement for claims balancing rules and SBR segment information.

Patient Account/Control Number(s) in 837:

• Special characters or spaces will not report back to an 835 or provider voucher.
• There are limitations on Patient Account reporting to the provider voucher (835 does not have these limitations)
  o Facility – 15 characters
  o Professional – 12 characters

If a reported patient account number exceeds the allowable characters, only the first eligible characters will be reported back on the paper provider voucher.
Paper Claim Submissions

The preferred method to submit claims to us is electronically. We follow the National Uniform Claim Committee (NUCC) official CMS 1500 Health Insurance Claim Reference Instruction Manual and UB 04 Data Specification Manual for definition, field attributes and notes with a few exceptions.

- The NUCC manuals are located online at nucc.org.
- The BCBSVT variances are posted to our provider website in the section entitled Provider Handbook & Reference Guides:
  - Professional billing: CMS 1500 Claim Instructions
  - Facility billing: UB-04 Billing Instructions
  - Facility billing: Outpatient services requiring the submission of CPT/HCPCS code

All required fields must be populated. Our system validates all information. If it is missing or inaccurate, the claim will deny on the provider voucher and require correction and resubmission.

Patient Account/Control Number(s):

- Special characters or spaces may not report back to an 835 or provider voucher, it will depend on how the claim is entered into our system.
- There are limitations on Patient Account reporting to the provider voucher (835 does not have these limitations)
  - UB 04 – 15 characters
  - CMS 1500 – 12 characters

If a reported patient account number exceeds the allowable characters, only the first eligible characters will be reported back on the paper provider voucher.

Do not mail paper claims to us. Instead, use one of the options below:

- Fax to “Attention Claims Department” at (866) 334-4232 or
- Email (make sure you send through a secure method) to claims@bcbsvt.com

Note: This should not happen, but if your fax fails and you have an older fax machine, when re-sending, make sure you send the entire fax again from the beginning. Older fax machines tend to pick up the page where the fax started to fail, and the entire file is not received by us.
How to Avoid Paper Claim Processing Delays

Please avoid the following to promote faster claim processing:

- The alpha prefix or alpha characters in an identification number must be reported as capital letters
- Missing or invalid information
- Hand-written claim forms
- Claim forms that are too light or too dark
- Poor alignment of data on the form
- Forms printed in non-black ink

Submitting Attachments with Claims

Attachments are generally not needed for claim processing. Do not attach the following information to a paper claim:

- Medical documentation, unless instructed to do so.
- Tax ID and address changes.

The following information must be attached to the applicable claims:

- Coordination of benefits (COB) information (primary carrier explanation of benefits)—paper claims only.
  - Note: We do not accept the CMS accelerated or advanced payment reports. When it is necessary to submit a claim to us for processing after Medicare, the Medicare Explanation of Benefits must be provided. (See the Medicare Supplemental and Secondary Claim Submission section in this handbook for full details.)
- Descriptions for the following codes: NEC (not elsewhere classified), NOS (not otherwise specified) along with operative notes or other supporting documentation.
- Modifiers requiring documentation, such as modifier 22, 62, or 66 (please refer to modifier section below for more information).

Frequent Issues with Paper Claim Submissions

Below are some of the frequent issues we find with paper claim submissions that result in delays in processing or denials:

- Prefixes must be reported as capital letters, lower case are not easily read by our scanners which can result in denials or delays in processing.
- CMS 1500 form
  - Item number 6 – Patient’s Relationship to Insured
If the patient relationship indicates “self,” but the Patient’s Name (item number 2) reports a name that is different than the Insured’s Name (item number 4), the claim is returned to the provider for correction of either:
  o patient’s relationship to insured (item number 6), or
  o Patient’s name (item number 2).

Reminder: the “Patient Relationship to Insured” indicates how the patient is related to the insured. “Self” would indicate that the insured is the patient.

- UB 04 form
  Form locator 59 – Patient’s Relationship to Insured

The accepted codes for the relationship of the patient to the identified insured follow the National Standards, which are:

<table>
<thead>
<tr>
<th>Code</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Spouse</td>
</tr>
<tr>
<td>18</td>
<td>Self</td>
</tr>
<tr>
<td>19</td>
<td>Child</td>
</tr>
<tr>
<td>20</td>
<td>Employee</td>
</tr>
<tr>
<td>21</td>
<td>Unknown</td>
</tr>
<tr>
<td>39</td>
<td>Organ Donor</td>
</tr>
<tr>
<td>40</td>
<td>Cadaver Donor</td>
</tr>
<tr>
<td>53</td>
<td>Life Partner</td>
</tr>
<tr>
<td>G8</td>
<td>Other Relationship</td>
</tr>
</tbody>
</table>
Section 6.4

ClaimsXten-Select™ and Clear Claim Connect (C3)

We utilize ClaimsXten-Select™ software to assure accuracy and consistency in claims processing for both professional (CMS HCFA-1500) and outpatient facility (UB-04) based claims.

An overview of ClaimsXten-Select™ and the edits that are applied are located in CPP_32 ClaimsXten-Select™ Edits Payment Policy is located on our non-secure provider website under Policies.

Exceptions to ClaimsXten-Select™ Logic:

- Behavior Change Interventions
  - CPT codes 99408 and 99409 are not subject to ClaimsXten-Select™ logic when billed in addition to the following evaluation and management codes: 99202-99215, 99281-99285, 99381-99387, or 99391-99397

- After Hour Services
  - CPT code 99050 are not subject to ClaimsXten-Select™ logic when billed in addition to the following evaluation and management codes: 99202-99205, or 99211-99215 see “After Hour Services” below.

Upgrades to ClaimsXten-Select™ Logic:

The ClaimsXten-Select™ software is upgraded quarterly. The dates of the upgrades will vary. Advance notice is posted to the What’s New area of our provider website, advising of the upgrade date and any related details.

ClaimsXten-Select™ logic is applied based on date of processing, regardless of date of service. Claims processed prior to an upgrade and require an adjustment will be subject to the upgraded ClaimsXten-Select™ logic, regardless of the date of service.

Edits are not retroactively applied to the ClaimsXten-Select™ edits. Any changes are as of the upgrade date forw

ClaimsXten-Select™ Logic Review:

A ClaimsXten-Select™ logic review is a request by a provider for review of the logic supporting the processing of claims. Prior to filing for a ClaimsXten-Select™ review, the processing of the claim should be reviewed through the Clear Claim Connection™ (C3) tool, which is available on our Provider Resource
Center (registration required). C3 will provide a full explanation of the logic behind the processing of the claim.

A ClaimsXten-Select™ logic review request may only be submitted in the following circumstance:

A provider has locally or nationally recognized documentation that supports other possible logic. If a provider disagrees with the ClaimsXten-Select™ logic, a request for review may be submitted by calling or writing to your provider relations consultant within 180 days from the original provider voucher date. The provider must supply copies of all supporting documentation relied upon for use of a different logic than that currently in use by BCBSVT. Our ClaimsXten-Select™ Committee will review the information and notify the provider in writing of the final decision of the Plan.

Note: A ClaimsXten-Select™ review of a specific claim should not be filed. If the claim was subject to extreme circumstances, our provider claims review process set forth above should be followed. If, in reviewing a denial of a claim based on ClaimsXten-Select™, it is determined that a modifier or CPT code should be added/changed, the claim should be resubmitted as a Corrected Claim (as described above). We stand behind all ClaimsXten-Select™ logic and will uphold all denials for routine cases.

Clear Claim Connection™ (C3)

C3 is a web-based application that enables us to disclose coding rules and edit rationale* to our provider network. Providers can access any of this information via our Provider Resource Center (registration required). The system increases transparency and helps us educate our physician community on conceivably complex medical payments.

*C3 results/information does not include benefits, medical policies, all payment policies, or member claims history. It only applies coding rules and edit rationale based upon information provided.

There are edit specific limitations with the tool that may not provide an accurate response on the following rules:

- Post-operative visit
- Pre-operative visit
- Same day visit
- Global comp
- New patient code for established patients
- Anesthesia multi-crosswalk
- Anesthesia not eligible to bill
- Anesthesia standard crosswalk
- Medicare Medically Unlikely Edits (MUE) Durable Medical Equipment (DME)

Full descriptions of these edits are available in CPP-32 ClaimsXten-Select Edits payment policy, located on our non-secure provider website under Policies.

Location and Using the C3 tool:

- Go to the BCBSVT provider website: www.bcbsvt.com/provider-home.
- Sign into the Provider Resource Center.
• Click on “Claim check analysis via the Clear Claim Connection™ (C3).”
• Review and accept terms and conditions
• You will then be required to complete the following fields (unless noted otherwise):
  o Claim type
    ▪ Professional
    ▪ Facility (outpatient)
    ▪ Facility (inpatient)
  o Gender
    ▪ Male (default selection if nothing is chosen)
    ▪ Female
  o Date of Birth in mm/dd/yyyy format
    ▪ Must be less or equal to date of service
  o ICD Code Set – this is an option field
  o Diagnosis – this is an optional field
  o Bill Type
    ▪ Field pre-populates only if facility claim type was selected
      • Outpatient – 131
      • Inpatient – 111
  o Claim Line Fields (it is required to complete at least one claim line)
    ▪ Procedure – enter valid CPT or HCPCS code
    ▪ Modifier – optional, enter as a two-digit code
    ▪ Quantity – optional, defaults to 1
    ▪ Revenue Code – only required if facility is selected
    ▪ Billed Amount – optional, defaults to 100
    ▪ DOS From – defaults to current day but can be changed using the mm/dd/yyyy format
    ▪ DOS To - defaults to current day but can be changed using the mm/dd/yyyy format
    ▪ Provider State – optional, chose from drop down selection
    ▪ Place of Service – defaults to 11-office but you can choose from a drop down selection
    ▪ Diagnosis – optional

Then click Review Audit Results Button or press Enter. Results will be displayed.

To bring up an empty entry screen, claim on the “clear” button.

Providers can run claims through C3 for a determination of claims editing in advance of claim submission, or after claim submission to explain the logic used in processing the claim.

We encourage providers to use this tool to better understand the logic behind claims processing.

**Accuracy of the Results You Receive in C3**: The accuracy of the results you receive in C3 will be based upon the information you supply.

The ClaimsXten-Select™ software used in our processing system reviews claims history when editing. C3 is not connected to any claims or member data. If you are completing a C3 review, to get an accurate
result, you will need to enter all services provided in the look-up tool. For example: If an office visit occurs a day earlier than a surgery, you would want to enter the office visit and date along with the surgery and date to make sure there is not any preoperative logic.
Section 6.5

Coordination of Benefits (COB)

COB is the process that determines which health care plan pays for services first when a patient is covered by more than one health care plan.

- The primary insurance is responsible for paying the benefit amount allowed by the member’s contract
- The secondary insurance is responsible for paying any part of the benefit not covered by the primary plan (as long as the benefit is covered by the secondary insurance)

In most cases, the total paid by both plans may provide payment up to, but not exceeding, our allowed price. For BlueCard claims, refer to the BlueCard specific section for details.

If COB applies, the primary carrier’s Explanation of Benefits (EOB) must be attached to the claim and the following areas of the CMS 1500 must be completed:

- Box 9: other insured’s name
- Box 9 a-d: other insured’s policy or group number
- Box 11d: marked “yes” — unless Medicare or Medicaid is the primary insurer, then mark “no”
- Box 29: amount paid

837 HIPAA compliant transaction requirements can be found in our online 837 companion guides, available at bcbsvt.com/provider on the electronic business page.

For BlueCard COB, please refer to the BlueCard section in this handbook.

Coordination of Benefits (COB) – Members with more than one BCBSVT Policy

Some members have more than one policy with BCBSVT. In these cases, the claim needs to be submitted to BCBSVT (electronically or on paper) under the primary insurance identification number with the secondary BCBSVT policy in the other insurance field.

We will process the claim under the primary coverage and then under the secondary. This process can take up to 30 days to complete. We request you hold any secondary claim submission until you have verified the status of the claim BCBSVT crossed to the secondary policy.
Work-Related Injuries and COB

General:

For our members, injuries which are work related are an exclusion of our certificates. We do not coordinate with worker’s compensation carriers or consider balances after worker’s compensation makes payment. We do, however, allow consideration of services where worker’s compensation has denied the claim as not work related.

Providers cannot bill us if:

• A member informs you that they are seeking care for a work-related injury or condition, or
• You have actual or constructive knowledge that the member is actively considering or pursuing worker’s compensation coverage, or
• You have an actual or constructive knowledge that the member’s care has been approved for worker’s compensation coverage.

If you suspect but are not certain whether the care rendered is for a work-related injury or condition, you may submit the claim to us. Make sure to indicate on the claim form that the injury is a work-related injury or condition.

If a claim is denied by the worker’s compensation carrier it can then be submitted to us for consideration of benefits. Make sure to include the worker’s compensation carrier’s explanation of processing as timely filing will be 180 days from the other carrier’s processing, not the date of service.

COVID-19 Exposure in the Workplace:

Claims should not be submitted to us for members that are either front-line workers or non-front-line workers identified by recent Vermont law (described below). Instead, these claims should be submitted to the patient’s worker’s compensation carrier.


The first presumption is that, in the case of a front-line worker, disability or death resulting from COVID-19 is compensable under worker’s compensation policies provided that the front-line worker receives

• a positive laboratory test for COVID-19 between March 1, 2020, and January 15, 2021, or
• a diagnosis of COVID-19 from a licensed healthcare provider between March 1, 2020, and January 15, 2021.

Act 150 defines “front-line workers” as individuals who are employed as:

• Firefighters;
• certified law enforcement officers;

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• emergency medical and volunteer personnel;
• workers in a health care facility or in an institution or office where health care services are provided by licensed healthcare professionals;
• correctional officers;
• workers in a long-term care facility or residential care facility;
• childcare providers permitted to provide childcare to the children of other front-line workers;
• home health care workers or personal care attendants;
• workers in a morgue, funeral establishment, or crematory facility; and
• workers performing services that place them at a similarly elevated risk of being exposed to or contracting COVID-19 as the occupations listed above.

Please note that the law does not explicitly include teachers or those working in schools as front-line workers. For these patients, we encourage you to ask how they may have contracted COVID-19.

To overcome the presumption for front-line workers, a worker’s compensation insurer must demonstrate that the infection is due to non-work exposure or risk factors.

The second presumption is available for other workers that have a positive test and have either a documented exposure to COVID-19 while working or are able to show that they performed services at a location where others present had COVID-19 at the time or tested positive within 14 days. This presumption can be defeated if the worker’s compensation carrier can demonstrate the infection was due to non-work-exposure or risk factors OR by demonstrating the employee’s place of employment complied with applicable state and federal guidance for workplaces.

Worker’s compensation insurance provides workers with access to lost wages, as well as covering medical bills, and it is important that people have access to these benefits if they are entitled to them. As a reminder, work-related injuries are an exclusion of BCBSVT member certificates.

This means that you should not submit to BCBSVT claims for COVID-19-related testing, diagnosis, and treatment for members that are either front-line workers or non-front-line workers that fit within the parameters of the second presumption above. Such claims should be submitted to your patient’s worker’s compensation insurer for appropriate disposition.

If you suspect, but you are not certain the COVID-19-related services are work-related, you are not required to submit a claim to BCBSVT. There may be circumstances, however, when you wish to submit a claim to BCBSVT. For instance, you may believe you will receive other information indicating the injury is not-work related and no claim will be made to the worker’s compensation carrier, but there is risk this information may not be received within the BCBSVT 180-day timely filing window. In these circumstances, be sure to indicate on the claim form that the injury is a work-related injury or condition. Please note that the claim will be denied, but if you subsequently learn from a source other than a denial or rejection from a worker’s compensation carrier that the service is for an injury that is not work-related, you can submit a claim to BCBSVT.

related, but the window for timely filing has passed, we will use the date the original claim was submitted for determining benefits.

If a claim is rejected or denied by the worker’s compensation carrier, it can then be submitted to us for consideration of benefits. Please include the worker’s compensation carrier’s explanation of processing as timely filing will be 180 days from the other carrier’s processing, not the date of service.

**Exhausted Workers Compensation Benefits**

Once the Workers Compensation benefit is exhausted you need to submit the first claim on paper with a copy of the exhausted letter from the Workers Compensation carrier. The exhausted letter is placed on file and the claim processed accordingly. From that point forward, claims can be submitted electronically and do not need to include any further information related to the Workers Compensation benefit being exhausted.
Section 6.6

When Medicare Is the Primary Carrier

**Medicare Supplemental and Secondary Claim Submission – Coordination of Benefits Agreement (COBA)**

We participate in the Coordination of Benefits Agreement (COBA) Program with the Centers for Medicare and Medicaid Services (CMS). This means that most direct claim submissions for these types of claim are not required, including claims CMS classifies as “Mass Adjustments”.

**Exclusion:**

FEP members who reside in a State other than Vermont, claims are forwarded to the State in which the member resides, rather than the State where the services were rendered. These secondary claims need to be submitted directly to us. If you are submitting on paper, you must include a copy of the Explanation of Medicare Payment (EOMP) for that member.

**How COBA works:**

- We provide the Medicare Intermediary (MI) with a membership file monthly
- When the MI matches a claim with our member, the claim is crossed over to us for consideration of benefits
- Explanation of payment from the MI to the provider indicates the claim has been forwarded to a supplemental insurer.
- Once we receive the claim from the MI, we process according to the member’s benefit and provider contract and generate a provider voucher with payment, if applicable.

If the MI is unable to match a member’s claim to our membership file, the EOMP to the provider will indicate that the claim has not been forwarded to a supplemental insurer (BCBSVT). In this case, the provider needs to submit the claim directly to us. Reminder, if you are submitting on paper, remember to EOMP for that member.

**Quick Tips:**

- Do not submit Medicare-related claims to us before receiving/review your EOMP
If the EOMP indicates that the claim was forwarded, you must wait 30 days from the date of your EOMP before submitting the claim directly to us for consideration. Claims received before the 30-day mark will be denied/returned.

Prior to submitting a Medicare supplemental/secondary claim directly to us, you should verify if we have the claim on file, either online or by calling our customer service team.

- We do not accept the CMS accelerated or advanced payment reports. When it is necessary to submit a claim directly to us for processing, the EOMP must be included.

**Other Blue Plans that participate in the COBA program**

When claims are crossed over to another Blue Plan through the COBA program and the services were rendered by a BCBSVT participating provider and payment is due, an 835 is generated and forwarded to BCBSVT for provider pick up. Please see the 835 section in this handbook for details.

**Medicare Adjusted Claims**

Medicare Adjusted claims are forwarded to the appropriate Blue Plan through the COBA program, direct claim submission is typically not required.

However, if the Medicare adjusted claim did not cross to the member’s Blue Plan or the claim has not processed in 30 days of the Medicare cross over, you will need to submit a claim to the member’s Blue Plan directly. Claim submissions can be on paper or electronic. Remember, if you submit on paper a copy of the Medicare Explanation of Payment will need to be included.

BCBSVT does not accept Medicare adjusted claims for another Blue Plan members.

**Adjustments/Corrected Claims**

Adjustments and Corrected claims must be filed within 180 days for the date of the original BCBSVT processing unless stated otherwise in provider contract.

See the BlueCard section for specific on BlueCard Adjustments/Corrected Claims.

An adjusted/corrected claim is one which:

- Processed through to a provider voucher. If you are adding information, correcting information, or following the original provider voucher instructions, a corrected claim needs to be submitted. This can be done on paper or through an electronic transaction or

**Note:** If you are changing a member’s identification number and/or alpha prefix, do not submit as an adjusted/corrected claim. It must be submitted as a new claim.

Complete details on how to submit adjusted/corrected claims are located:

• Electronic Claims: on our provider website at www.bcbsvt.com under Electronic Data Interchange/837 (professional or institutional) Companion Guide.

Special Billing Instructions for Rural Health Center or Federally Qualified Health Center

In most cases, you should not have to submit Medicare secondary/supplemental claim directly to us as they cross over directly through the COBA program. For exclusions and details of the COBA program, see the information under “Medicare Supplemental and Secondary Claim Submissions” earlier in this section.

If you do have a need to submit a Medicare secondary/supplemental claim to us, submit the claim on paper in the format you submitted to Medicare (either a CMS 1500 or UB 04) and attached the EOMP.

Claims Where Medicare Is Primary and an ICD-10-CM Manifestation Code Is Reported as the Primary Diagnosis

We do not allow manifestation codes to be reported as a primary diagnosis.

• COBA claims received by us reporting a manifestation diagnosis code will be returned/denied.
  o You will need to update the claim to report the primary diagnosis (other than a manifestation code) and submit as a corrected claim. If you are submitting the correction on paper, make sure to include the EOMP

• If you are submitting the claim directly to us for consideration as it did not cross over through the COBA program, your claim needs to report a primary diagnosis other than a manifestation code.
  o If you are submitting the correction on paper, make sure to include the EOMP

BCBSVT Contracted Providers Not Participating with Medicare or Opting Out of Medicare

Providers may participate with BCBSVT but elect not to participate with Medicare (either accepting or not accepting Medicare assignment) or opt out of Medicare entirely. In these scenarios, determining coverage where a member has Medicare primary coverage and BCBSVT secondary coverage can be complicated. Here are some general guidelines:

(a) Provider does not participate with Medicare
Some providers chose not to participate with Medicare but will still agree to treat Medicare patients. These non-participating providers may choose to either accept or not accept Medicare’s approved non-participating amount for health care services as full payment (also referred to as “accepting assignment”).

In cases where a provider does not participate with Medicare but does accept assignment, the provider agrees to accept the non-participating allowance as payment in full. The provider bills Medicare and Medicare pays 80% of the non-participating allowance. As we participate in the Coordination of Benefits Agreement (COBA) Program with the Centers for Medicare and Medicaid Services (CMS), the claim will cross over directly for processing through our system. A provider voucher and any eligible payments will be made directly to the provider. A provider may collect from the member any payments Medicare may have made directly to the member as well as any member liabilities (under the BCBSVT policy) not collected at the time of service. Please note, however, that for BCBSVT members with secondary benefits, the ceiling for payment is the difference between what Medicare paid and BCBSVT’s allowed amount.

In cases where the provider does not participate with Medicare and does not accept assignment but agrees to treat Medicare patients, the provider is permitted to charge an amount up to Medicare’s “limiting charge.” (Please note that some provider types, such as durable medical equipment suppliers, are not restricted by the limiting charge.) The provider must submit claims for services directly to Medicare on behalf of members. Medicare will pay the member 80% of the non-participating allowance. The claim will cross over directly for processing through our system. A provider voucher and any eligible payments will be made directly to the provider. The provider may collect from the member any payments Medicare made directly to the member as well as any member liabilities (under the BCBSVT policy) not collected at the time of service. Please note, however, that for BCBSVT members with secondary benefits, the ceiling for payment is the difference between what Medicare paid and BCBSVT’s allowed amount.

We expect that all contracted providers not participating with Medicare will follow all applicable Medicare rules, including any rules governing interactions with, or notices to, patients or to BCBSVT.

(b) Provider has opted out of Medicare

Some provider types may elect to opt out of Medicare. An opt-out provider does not accept Medicare at all and has signed an agreement (sometimes referred to as an affidavit) to be excluded from the Medicare program. These providers may charge Medicare beneficiaries whatever they want for services, but Medicare will not pay for the care (except in emergencies). Additionally, the provider must give the member a private contract describing the provider’s charges and confirming the patient’s understanding he/she is responsible for the full cost of care and Medicare will not reimburse. Finally, the provider does not bill Medicare.

Providers eligible to opt out include: doctors of medicine, doctors of osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical psychologists, clinical social workers, and registered dieticians and nutrition professionals. Providers not eligible to opt out include chiropractors, anesthesiologist assistants, speech language pathologists, physical therapists, occupational therapists, or any specialty not eligible to enroll in Medicare.
In situations where the member has Medicare as primary coverage and BCBSVT secondary coverage, and the services at issue are covered by BCBSVT, the provider should not collect from the member any amounts that exceed the applicable Copayment, Deductible, or Coinsurance amounts under the BCBSVT secondary policy. When billing us for a member with a secondary policy, the provider must submit a copy of the approval of opt-out letter from Medicare along with the claim form. Opt-out providers must notify their Medicare eligible members, prior to services being rendered, and must have the member sign a Medicare private contract, in which the member agrees to give up Medicare payment for services and pay the provider without regard to any Medicare limits that would otherwise apply to what the provider could charge. The member is responsible for anything the BCBSVT secondary plan does not cover, but the provider is bound to accept BCBSVT’s allowed amount for covered services as payment in full. To the extent the provider charges the member in an amount that exceeds the applicable Copayment, Deductible, or Coinsurance amounts due under the BCBSVT secondary policy, the provider must refund the member.

We expect that all contracted providers opting out of Medicare will follow all applicable Medicare rules, including any rules governing interactions with, or notices to, patients or to BCBSVT.

Submission of Traditional Medicare-Related Claims or Medicare Advantage Claims for Other Blue Plan Members

See Section 7 BlueCard for details.
Section 6.7

Claim Specific Guidelines

This section provides specific instruction of claim submission requirements for specific services, modifiers, provider types, etc.

Topics are listed alphabetically.

Notifications of revisions to this section are posted to the provider website or published in FinePoints, our newsletter for providers.

Medical policies and benefit restrictions related to services are available on our provider website, or by contacting your provider relations consultant.

For BlueCard® members, medical policies and benefits are determined by the member’s Blue Plan. Contact the member’s Blue Plan directly for details or use the online medical policy router for a link to specific medical policies. To use the medical policy router, you will need the member’s alpha prefix.

For FEP medical policies and benefits, please contact our FEP Customer Service team at (800) 328-0365.

Our Payment Policies are located on our non-secure provider website under Policies.

We reserve the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in payment and/or medical policies. If an audit identifies instances of non-compliance with a payment policy, we reserve the right to recoup all non-compliant payments. To the extent the Plan seeks to recover interest, Plan may cross-recover that interest between BCBSVT and TVHP.

Acupuncture

Our Payment Policy on Acupuncture lists the services that are eligible for reimbursement. Services that are not eligible for reimbursement may be billed to the member if (1) the services are within the scope of the provider’s license and (2) the provider obtains a waiver from the member following the process defined in this Provider Handbook.

Our payment policy for acupuncture is located on our non-secure provider website under Policies.

After Hours Coverage

Providers who see patients in the office after the normal posted business hours or holidays * for situations that would otherwise require more costly urgent care or emergency room settings, CPT code 99050 is eligible for reimbursement in addition to basic service code(s).

- CPT code 99050 is not subject to ClaimsXten-Select™ logic when billed in addition to the following evaluation and management codes: 99202-99205, or 99211-99215.
• If you are a provider who is reimbursed on a capitated fee schedule, CPT 99050 processes as capitated.

The claim does not need supporting documentation, however, the patient’s chart must indicate the day and time when services were rendered and the place of service on the CMS 1500 form needs to reflect office (POS 11).

Related CPT codes (99051-99060) are subject to the incidental ClaimsXten-Select™ logic.

The Federal Employee Program (FEP) does not provide benefits for after hour services.

*SERVICES RENDERED ON HOLIDAYS - The following holiday observances will be recognized: New Year Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

**Allergy**
For injection of commercially prepared allergens, use the appropriate CPT code for administration. For codes indicating “more than ___ test,” the specific number of tests should be indicated on the claim form in item 24g. One unit equals one test.

Use the appropriate CPT/HCPCS drug code if billing for the injected material.

**Ambulance**
Report the ambulance pick-up zip code on the claim submission.

Paper claims need to report the pick-up zip code in item 23. Electronic claims need to report the pick-up zip code in loop 2310E.

Claims must be submitted to the Blue Plan where the member was picked-up. Only pick-up zip codes in Vermont can be submitted to BCBSVT. Any claim received without a Vermont zip code, will be denied and need to be submitted to the appropriate Blue Plan.

NOTE: Medicare primary claims crossed over from COBA are exempt from this billing requirement.

**Ancillary Claim for BlueCard®**
Defined as Durable Medical Equipment, Independent Clinical Laboratory and Specialty Pharmacy have special claim filing rules. Details are provided under the Durable Medical Equipment, Clinical Laboratory (Independent) and Specialty Pharmacy categories below.

**Anesthesia**
See section 6.7A in this handbook for full details.

**Bilateral Procedures**
For bilateral procedures when there is no specific bilateral procedure code, use the appropriate CPT code for the first service, and use the same code plus modifier 50 for the second service. The order in which services report on the claim does matter for pricing to be correct. However, the first line should not contain the modifier—the 50 modifier should be used only on the second line.

**BiPAP Supplies**
See Frequency of Supplies (Diabetic and CPAP/BiPAP) in this section for full details.
Biomechanical Exam
Use office visit codes for biomechanical exams.

Breast Pumps
When billing for BlueCard members, see instructions, “Ancillary Claim for BlueCard,” Durable Medical Equipment.

Clinical Trials
Medicare Advantage claims must report a clinical trial number.
- Electronic 837 transactions report in 2300 loop REF*P4 segment
- Paper – To be determined

Colonoscopy
If a BCBSVT member has opted to have a Fecal Immunochemical Test/Cologuard test, regardless of the FIT/Cologuard test result, the follow up colonoscopy must be billed as a preventive screening.

We consider the following procedures, when billed with a diagnosis code noted to be preventive:

**Procedures:** 44401, 45330, 45331, 45333, 45334, 45338, 45346, 45378, 45380, 45381, 45382, 45384, 45385, 45388, G0104, G0105, G0121, S0285

**Diagnosis Codes:** D12.0, D12.2, D12.3, D12.4, D12.5, D12.6, D12.7, D12.8, D12.9, D50.9, K63.5, Z00.00, Z00.01, Z12.10, Z12.11, Z12.12, Z12.13, Z13.81, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z85.070, Z85.078, Z86.010, Z86.018, Z87.19

Computer Assisted Surgery/Navigation
See Robotic & Computer Assisted Surgery/Navigation in this section for full details.

CPAP Supplies
See Frequency of Supplies (Diabetic and CPAP/BiPAP) in this section for full details.

COVID-19 Administration and Vaccine
When billing for administration of the COVID-19 vaccine, the appropriate code for the vaccine itself must also be reported on the claim. The applicable vaccine code must be reported with no modifier (DO NOT bill a modifier -SL) and a zero charge, or if your system is not capable of a zero charge, $0.01 can be billed.

<table>
<thead>
<tr>
<th>Code</th>
<th>Effective Date</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>91300</td>
<td>12/11/20</td>
<td>Pfizer- BioNTech vaccine</td>
</tr>
<tr>
<td>91301</td>
<td>12/18/20</td>
<td>Moderna vaccine</td>
</tr>
<tr>
<td>91302</td>
<td>Pending FDA Approval</td>
<td>AstraZeneca vaccine</td>
</tr>
<tr>
<td>91303</td>
<td>02/27/21</td>
<td>Janssen (Johnson &amp; Johnson) vaccine</td>
</tr>
<tr>
<td>0001A</td>
<td>12/11/20</td>
<td>Pfizer- BioNTech administration first dose</td>
</tr>
<tr>
<td>0002A</td>
<td>12/11/20</td>
<td>Pfizer- BioNTech administration second dose</td>
</tr>
<tr>
<td>0011A</td>
<td>12/18/20</td>
<td>Moderna administration first dose</td>
</tr>
</tbody>
</table>
Administration codes (except M0201) are considered for benefits without member liabilities. M0201 is considered informational and does not provide any additional reimbursement, except supplemental policies, which will consider Medicare reported patient liabilities. The vaccine is not eligible for reimbursement as it is being supplied by the federal government.

Reminder: COVID-19 administration and vaccines for Medicare Advantage members (this includes Vermont Blue Advantage members) need to be billed to the original fee-for-service Medicare Program.

**COVID-19 Monoclonal Antibody Treatment**

When billing for COVID-19 monoclonal antibody treatment (injection), the antibody itself must also be reported on the claim. The applicable antibody code must be reported, **no modifier** (DO NOT bill a modifier -SL) and a zero charge, or if your system is not capable of a zero charge, $0.01 can be billed.
Intravenous infusion, sotrovimab, includes infusion and post administration monitoring.

Intravenous infusion, sotrovimab, includes infusion and post administration monitoring in the home or residence; this includes a beneficiary’s home that has been made provider-based to the hospital during the covid-19 public health emergency.

Injection, bamlanivimab-xxx, 700 mg (Eli Lilly) Discontinued, expired 04/16/21

Injection, casirivimab and imdevimab, 2400 mg (Regeneron)

Injection, bamlanivimab and etesevimab, 2100 mg (Eli Lilly)

Injection, Sotrovimab, 500 mg

The antibody treatment (injection) is not eligible for reimbursement as it is being supplied by the federal government.

**Dental Anesthesia**
See section 6.7A in this handbook for full details.

**Dental Care**
See section 6.7F in this handbook for full details.

**Designated Agencies (Vermont)**
Our Quality Improvement Policy, Vermont Designated Agency provides the policy, scope, process and billing for the Designated Agencies.

The policy is located on the provider portal under Policies, then the Quality Improvement link.

**Diabetic Supplies**
See Frequency of Supplies (Diabetic and CPAP/BiPAP) in this section for full details.

**Diagnosis Codes**
Providers should always bill a defined diagnosis code when one is available.

We capture all diagnosis codes reported on a claim. For the application of benefits and medical policies, we use the first reported diagnosis code on the claim.

- If you receive a denial related to a diagnosis code and there is another reported diagnosis code that would be eligible, you do not need to submit a corrected claim*. Just contact the customer service team and they will initiate a review and/or adjustment.

*If the diagnosis is truly in the wrong position or incorrect, submit a corrected claim updating the placement or diagnosis code.
BlueCard® and FEP—BCBSVT sends all reported diagnosis code(s) to the member’s Plan or the FEP system. If you wish to change the order of the diagnosis codes, you must submit a corrected claim. This corrected claim adjustment may or may not affect the benefit determination.

ICD-10-CM Manifestation codes are not allowed to be reported as a primary diagnosis on BCBSVT claims. Medicare does allow the reporting of manifestation codes as a primary diagnosis. See Section 6.6, “When Medicare Is the Primary Carrier,” for details.

Please also refer to Section 6.1, “General Claim Information,” for details on industry-standard diagnosis code information.

**Diagnostic Imaging Procedures**

We have a payment policy for Multiple Procedure Payment Reduction – Diagnostic Imaging Procedures. The policy defines our payment methodology when two or more payable diagnostic imaging procedures are performed on the same patient during the same session. Our payment policy for Multiple Procedure Payment Reduction – Diagnostic Imaging Procedures is located on our non-secure provider website under Policies.

**Drugs Dispensed or Administered by a Provider (other than pharmacy)**

**Replacement Drugs:** In cases where the original drug was a loss (improper storage, undelivered, expired, etc.), the replacement drug can be submitted for consideration of benefits, but only after the original claim for the drug is recovered. You can initiate a recovery by completing a provider overpayment form indicating billed in error, or if you bill electronically, submit a corrected claim. It is our expectation that the party responsible for the loss of the drug must cover the cost of the drug that was a loss. Members cannot be held liable for replacement drugs.

Claims with drug services must contain the National Drug Code (NDC) along with the unit of measure and quantity in addition to the applicable Current Procedural Terminology (CPT) or Health Care Procedure Coding System (HCPCS) codes(s). This requirement applies to drugs in the following categories:

- Administrative
- Miscellaneous
- Investigational
- Radiopharmaceuticals
- Drugs “administered other than oral method”
- Chemotherapy drugs
- Select pathology
- Laboratory
- Temporary codes

The requirement does not apply to durable medical equipment.

Acceptable 5010 values for the NDC Units of Measurement (UoM) Qualifiers are as follows:

<table>
<thead>
<tr>
<th>Unit of Measure</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>F2</td>
<td>International Unit</td>
</tr>
</tbody>
</table>
Please refer to our online CMS (item number 24a and 24b), UB-04 (form locator 42 and 44) instructions or HIPAA compliant 8371 or 837P companion guide (section 1.11, NDC) for full billing details.

We have posted a National Drug Code (NDC) Provider Tool to our Provider Resource Center. It is intended to assist practices in determining the unit of measure that needs to be reported to us.

**Dry Needling**

There are two CPT® codes designated for dry needling.

- 20560 – Needle insertion(s) without injection(s); 1 or 2 muscle(s)
- 20561 – Needle insertion(s) without injection(s); 3 or more muscles

Dry needling, per our Corporate Medical Policy for Myofascial Trigger Points, will deny as investigational for BCBSVT members, except for the two products noted below.

- State of Vermont employees (prefixes EVT and FVT) have benefits available for the above services (subject to terms and conditions of their contract) when rendered by a Physical Therapist, Chiropractor, or Allopathic Physician. When eligible, these services will apply to appropriate physical therapy or chiropractic benefit maximums.

- FEP (prefix R) considers the services to be surgical, and applicable benefits are applied.

**Durable Medical Equipment (DME)**

These guidelines apply to DME suppliers and professional providers who supply DME.

DME rentals require “from” and “to” dates on claims, but the dates cannot exceed the date of billing.

DME claims for BlueCard® members report to the member’s Blue Plan, the DME supplier’s contractual arrangement, to include the bulleted items below.

FEP and BCBSVT/NEHP/ABNE tracks ALL rental-to-purchase for all items. In addition, claims will require the following bulleted items below.

- Rental-to-purchase:
  - Rental-to-purchase contractual pricing arrangements must be included in claim transmission with member’s Blue Plan.
  - Member’s Blue Plan will track rental-to-purchase amounts and can deny amounts over the purchase price as provider liability.
- DME HCPCS Level II codes can be categorized as:
  - Purchase only—Note: if a purchase only code is billed as rental, the claim will be rejected on a provider voucher.
When billing a rental claim or submitting a claim for a code that is considered rental only, modifier –RR is required to ensure correct processing and reimbursement.

- Example: This code is categorized as rental only and should be submitted with modifier –RR:
  E0424 – Stationary compressed gaseous oxygen system rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing.

- Example: This code is categorized as a rental-to-purchase claim submission for the rental and requires modifier –RR be submitted to ensure correct processing and reimbursement:
  E0601 – Continuous positive airway pressure (CPAP) device

**Claims submission guidelines for BlueCard®:** Claims are to be submitted to the Plan in whose service area the equipment was shipped to or purchased at a retail store.

A complete claim submission flow chart is available on our provider website under Provider Handbook & Reference Guides/General/Durable Medical Equipment Claim Submission Flow Chart for BlueCard®.

Note: When billed as a home place of service, the member’s address determines the local Plan.

**Evaluation and Management Reminder**

**Current Procedural Terminology (CPT®) guidelines** recognize seven components, six of which are used in defining the levels of evaluation and management services. These components are:

- History
- Examination
- Medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

The first three are considered the **key components** in selecting a level of evaluation and management services.

The next three components are considered contributory factors in the majority of encounters. Although counseling and coordination of care are important evaluation and management services, these services are not required at every patient encounter.

The final component, time, is provided as a guide. However, it is only considered a factor in defining the appropriate level of evaluation and management code when counseling and/or coordination of care dominates the physician/patient and/or family encounter. Time is defined as face-to-face time, such as
obtaining a history, performing an examination or counseling the patient. CPT provides a nine-step process that assists in determining how to choose the most appropriate evaluation and management code. We apply this process when auditing medical and billing records, and encourage all practices/providers to become familiar with the nine-step process. Remember, however, that the most important steps (in terms of reimbursement and audit liability) are verifying compliance and documentation. If your practice utilizes a billing agent, it is still the practice’s responsibility to make sure correct coding of claims is occurring.

Please refer to a CPT manual for full details on proper coding and complete documentation.

**Federally Qualified Health Center or Rural Health Center**
See Rural Health Center or Federally Qualified Health Center later in the section.

**Flu Vaccine and Administration**
BCBSVT contracted providers, facilities and home health agencies cannot bill members up front for flu vaccine or administration. The rendering provider, facility or home health agency must submit the claim for services directly to us.

Every member who receives a flu shot must be billed separately. We do not allow for roster billing or billing of multiple patients on one claim. Both an administration and vaccine code must be billed for the service.

For billing of State-supplied vaccine/toxoid, please refer to “State-Supplied Vaccine” later in this section.

**When BCBSVT is the primary carrier:**

If the injected material* is not included on the claim and should be, the claim will be processed through the provider voucher requiring the correction of the claim.

The injectable material and administration* must be reported on the same claim, or a denial will occur.

*There is a 10-day look back on a claim submitted for an immunization administration for vaccine/toxoids codes 90460-90474. If there was a claim submitted within the 10-day window for the vaccine(s), the claim will process. If there is not a claim submitted within the 10-day window for the vaccine(s), the claim will deny.

**If another Insurer is primary:**

If the injected material is not included on the claim and should be, the claim may initially deny. If this occurs, you will need to contact the appropriate customer service team to have the claim adjusted.

**Frequency of Supplies (Diabetic and CPAP/BiPAP)**
We have a payment policy for Frequency of Supplies (Diabetic and CPAP/BiPAP). The policy outlines the frequency limits for diabetic, CPAP and BIPAP supplies. The policy is located on our non-secure provider website under Policies.

**Habilitative Services**
Some BCBSVT, BlueCard and FEP members have benefits available for habilitative services. Habilitative services, including devices, are provided for a person to attain a skill or function never learned or acquired due to a disabling condition.

When providing habilitative services for physical medicine, occupational or speech therapy, a modifier -96 must be reported, so services will accumulate to the correct benefit limit.

All other services for habilitative do not have special billing requirements.

**Health Risk Assessments (CPT® Codes 96160 or 96161)**
There is a known defect with the National Correct Coding Initiative (NCCI) when billing a Health Risk Assessment (96160 or 96161) and Immunization Administration (90460 or 90461) service on the same day for the same patient or billed under the same patient. The Health Risk Assessment denies inclusive to the Immunization Administration.

In order for both services to be considered for benefits, the edit must be bypassed by appending a modifier 59 to the Health Risk Assessment service. We understand that this is a coding violation under NCCI edits, but the modifier is necessary to “break” the NCCI code and have the claim process correctly.

**Home Births**
We have a payment policy for Home Births. The policy provides description, eligible and ineligible services and billing guidelines. Our payment policy for Home Births is located is located on our non-secure provider website under Policies.

**Home Infusion Therapy (HIT) Drug Services**
We have a payment policy for HIT. The policy provides general information, eligible and ineligible services, billing guidance and reimbursements. Our payment policy for HIT is located on our non-secure provider website under Policies.

**Hospital-Acquired Conditions**
See “Never Events and Hospital-Acquired Conditions” in this section for details.

**Hub and Spoke System for Opioid Addiction Treatment (pilot program)**
We have a payment policy for the Hub and Spoke System for Opioid Addiction Treatment. The policy defines what the pilot program is, benefit determinations and billing guidelines and documentation. Our payment policy for Hub and Spoke System for Opioid Addiction Treatment is located on our non-secure provider website under Policies.

**Immunization Administration**
See Section 6.7C for full details

**Incident To**
Also referred to as “supervised billing,” incident to billing is generally not allowed. Providers who render care to our members must be licensed, credentialed and enrolled. Exceptions are: Physical Therapy Assistants, Occupational Therapy Assistants and Mental Health Substance Use Disorder Trainees. Details on the requirements for Therapy Assistants and MHSUD Trainees are contained with this section.

**Inpatient Stay - Unit Billing**
We cover either the day of admission or the day of discharge, but not both. The units reported in form locator 46 (service units) of the revenue code for the room charge must be one less than the date span identified in form locator 6 (statement covers period from through).

For example, if you statement covers period from is 030121 and the through is 030321, then a revenue code line 0120 should report 2 units.

**Inpatient Hospital Room and Board, Routine Services, Supplies and Equipment**

We have a payment policy for the Inpatient Hospital Room and Board, Routine Services, Supplies and Equipment.

The policy provides a description, benefit determinations and billing guidelines and documentation. Our payment policy for Inpatient Hospital Room and Board, Routine Services, Supplies and Equipment is located on our non-secure provider website under Policies.

**Informational Only Codes**

CPT (Category II xxxxF)/HCPCS codes considered investigational only and reimbursement is not provided, see section 6.7E.

**Laboratory (Independent, Clinical)**

An Independent Clinical Laboratory is defined as a provider who bills place of service 81. Labs that are contracted with our Lab Benefit Manager (LBM), Avalon, should submit claims following the Avalon’s contractual requirements.

**Claims submission guidelines for BlueCard®:** Claims are to be submitted to the Plan in whose service area the specimen was drawn or collected, as identified by the ordering provider identification number supplied in:

- Paper CMS 1500 form – item number 17b
- Electronic – 837 Loop 2310A

There is one exception to the BlueCard® claim filing rule and that is, if the ordering provider (as identified in item 17b or loop 2310A) is located within a contiguous county to Vermont and is contracted (either directly or through a group contract) with BCBSVT, the independent lab can choose to bill BCBSVT directly.

For example: If the ordering provider is in Hanover, NH, contracted with BCBSVT through a group contract with BCBSVT and they sent a BCBSVT members specimen to an independent clinical laboratory in Maine, the lab service can be billed to BCBSVT.

In order to ensure correct claim processing, the claim needs to be submitted to BCBSVT on paper and “Contiguous County” needs to be written on the top of the claim form.

**Laboratory Handling**
Use the appropriate CPT code for handling charges when sending a specimen to an independent laboratory (one not owned or operated by the physician) or hospital laboratory, and when the claim for the laboratory work is submitted by the physician. Use place of service 11 when billing for this service.

**Laboratory Services Self-Ordered by Patient**
We require all laboratory services be ordered by a qualified health care provider. If a patient has self-ordered laboratory service(s), claim(s) cannot be billed to us. The member is financially liable and must be billed directly.

Notes:
- **Exception** COVID-19 Testing – members can self-refer for COVID-19 testing, claims should be billed, and an ordering provider does not need to be reported on the claim.
- BlueCard member’s benefits will be determined by the Blue Plan. Please be sure to verify benefits.
- Federal Employee Program members, please contact the FEP customer service at (800) 328-0365 for details.

**Locum Tenens**
Must be enrolled. Enrollment information is in Section 1.5. All services rendered by locum tenens must be billed using their assigned NPI number in form locator 24J.

**Mammogram Screening and Screening Additional Views**
See Section 6.7D for full details.

**Maternity billing for FEP**
The date of the last menstrual period must report on all maternity services.
- Paper claims CMS1500 – report in box 14
- Paper claims UB04 – report as occurrence code 10 in form locator(s) 31-34
- Electronic billing – refer to the 837 guide for details.

**Maternity (Global) Obstetric Package**
We have a payment policy for Global Maternity Obstetric Package. The policy provides description, eligible and ineligible services and billing guidelines. Our payment policy for Global Maternity Obstetric Package is located on our non-secure provider website under Policies.

**Medically Unlikely Edits**
We determine each services unit designation *(see the Unit Designation information in this section for full details).* For those with a multiple unit designation, we follow the Centers for Medicare & Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) guidelines.

This program is administered by our partner, Cotiviti. At this time application of MUE is retrospective and is not processed through the ClaimsXten-Select™ logic.

**Medicare Primary Claims**
See the Section 6.6, “When Medicare Is the Primary Carrier” for claims submission specifics.

**Medication Therapy Management (MTM):**
This is a new exploratory program to collect data related to MTM services, reimbursement is not provided. Non-dispensing pharmacist who are enrolled and credentialed* are eligible to bill for services using CPT® codes 99605, 99606 & 99607.

We collect the data from the claim and process to deny as informational, provider write off.

*see Section 1.5 for information to enroll for this program.

**Mental Health or Substance Use Disorder Trainee**

Our Quality Improvement Policy, Supervised Practice of Mental Health Substance Use Disorder Trainees provides the supervisor/trainee requirements and claim submission/coding requirements. The policy is located on the provider portal under Policies, then the Quality Improvement link.

**Modifiers**

See section 6.7B for full details.

**National Drug Code (NDC)**

The reporting of an NDC is required for professional, outpatient facility and home infusion therapy places of service for specific drugs. Refer to the section in this manual titled “Drugs Dispensed or Administered by a Provider (other than pharmacy) or Home Infusion Therapy.

**Never Events and Hospital Acquired Conditions**

Our payment policy for Never Events and Hospital Acquired Conditions. The policy provides description, eligible and ineligible services and billing guidelines. Our payment policy for Never Events and Hospital Acquired Conditions is located on our non-secure provider website under Policies.

The Never Events and Hospital Acquired Conditions policy is administered by our partner, Cotiviti and the application of the policy is retrospective.

**Not Elsewhere Classified (NEC) or Not Otherwise Classified (NOS)**

Providers should always bill a defined code when one is available. If one is not available, use an unlisted service (NEC or NOS), provide a description of the service along with office and/or operative notes. The medical note(s) must accompany the original claim.

**Observation Services**

We have a payment policy for Observation Services. The policy provides a description, eligible and ineligible services, and billing guidelines. Our payment policy for Observation Services is located on our non-secure provider website under Policies.

BlueCard claims only: Observations stays that convert into an inpatient admission/stay must have services billed on two separate claims; one claim for the observation services and one claim for the inpatient admission/stay.

- If a combined claim is received for the observation and inpatient admission/stay, the claim will be denied on the provider voucher with a CO152 denial “we cannot process this claim because the number of days between the first and last date of service do not equal the number of units on the room and board line for the type of bill”.
  - Separate claims for each service needs to be submitted for the processing to continue.

**Occupational Therapy**

See Therapy (physical and occupational) 8-minute rule in this section.
Occupational Therapy Assistant (OTA)
OTAs are expected to practice within the scope of their license. Their services must be directly supervised by an Occupational Therapist. The supervising occupational therapist needs to be in the same building and available to the OTA at the time patient care is given. Medical notes must be signed off by the supervising therapist. Claims for OTA services must be submitted under the supervising Occupational Therapist’s rendering national provider identifier.

Operating and Recovery Room Services and Supplies
We have a payment policy for Operating and Recovery Room Services and Supplies. The policy provides a description, eligible and ineligible services and billing guidelines. Our payment policy for Operating and Recovery Room Services and Supplies is located on our non-secure provider website under Policies.

Physical Therapy
See Therapy (physical and occupational) 8-minute rule in this section.

Physical Therapy Assistant (PTA)
PTAs are expected to practice within the scope of their license. Their services must be directly supervised by a Physical Therapist. The supervising physical therapist needs to be in the same building and available to the PTA at the time patient care is given. Medical notes must be signed off by the supervising therapist. Claims for PTA services must be submitted under the supervising Physical Therapist’s rendering national provider identifier.

Place of Service
We use the CMS definitions of places of service, however, below are some specific clarifications on our intent of billing the following place of service:

- **03**: Used to identify services in a school setting or school-owned infirmary for services the provider has contracted directly with the school to provide.
- **11**: Used for office setting or services provided in a school setting or school-owned infirmary when the provider is not contracted with the school to provide the services.
- **20**: Used to identify services in an urgent care setting. BCBSVT has specific requirements that must be meet for this place of service to be billed. Detailed information is in the payment policy for Urgent Care Clinics. The policy defines what an urgent care clinic is (free standing or hospital-based) and how the services should be billed. Our payment policy for Urgent Care Clinic is located on our non-secure provider website under Policies.
- **72**: a certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician is not a recognized place of service for BCBSVT primary claims. If a place of service 72 is billed, the claim will be denied. Note: Medicare secondary claims will be accepted and processed accordingly.
  - **Radiology Readings** – the place of service billed needs to be the place of service where the patient received the radiology services (outpatient, inpatient, other)

Pre-Operative and Post-Operative
Some surgical procedures have designed pre and/or post-operative periods. For those procedures (and associated timeframes) if an evaluation and management service is reported, the service will deny.
To determine if a surgery qualifies for pre and/or post-operative periods, use the Clear Claim Connection™ (C3) tool (details on how to use this tool are provided earlier in this handbook) on the secure provider website. Enter the surgical code being performed along with the evaluation and management code. You will need to make sure you indicate on each service line the specific date it will or has been performed.

**Pricing for Inpatient Claims**
Claims apply the facility contractual reimbursement terms in effect on the date of discharge for all facility claims.

**Provider-Based Billing**
We do not allow for provider-based billing (i.e. billing a “facility charge” in connection with clinic services performed by a physician or other medical professional). Our payment policy for Provider-Based Billing is located on our non-secure provider website under Policies.

**Provider Who Is Not Yet Enrolled/Credentialed Joining a BCBSVT-Contracted Provider Group**
Providers joining a contracted provider group but who are not yet enrolled/credentialed are not eligible to provide services or bill for services for Blue Plan members until they are enrolled and approved by the BCBSVT credentialing committee, even if the member signs a waiver agreeing to financial responsibility. The rationale for this policy is that it reduces potential member confusion when a member receives care for a participating provider group. The approval date of the credentialing committee serves as the effective date they can begin to provide services and bill for Blue Plan members. Credentialing approval is not retrospective.

The claim processing system supports the denial of these services and reports as a provider liability.

This rule does not apply for independent providers in the process of being enrolled/credentialed. In these cases, the provider will be treated as out of network and all requirements associated with out of network care apply.

**Rabies Vaccine (NOT rabies immunoglobulin)**
- 90675 Rabies vaccine, for intramuscular use
  - Code also administration of vaccine (90460-90474)
  - Code also significant separately identifiable E&M service when appropriate
  - Excludes: coding of each component of a combination of vaccine individually and immune globulins and administration (90281-90399, 96365-96375)
  - Includes: Imovax, Patient’s age for coding purposes, not for product license, RabAvert, Vaccine product only
- 90676 Rabies vaccine, for intramuscular use
  - Code also administration of vaccine (90460-90474)
  - Code also significant separately identifiable E&M service when appropriate
  - Excludes: coding of each component of a combination of vaccine individually and immune globulins and administration (90281-90399, 96365-96375)
  - Includes: Patient’s age for coding purposes, not for product license, Vaccine product only

**Radiology**
Reading (professional component) Only
Must be billed with a modifier 26
- Place of service billed needs to be where the member received the radiology services. For example, if the services were in the emergency room, the place of service billed needs to be emergency room.
- Date of service reported needs to be the date the radiology service occurred, not the date the radiology reading occurred.

Technical Component Only
- Must be billed with a modifier TC

If both the reading (professional component) and technical component are being billed, do not report any modifier(s).

Virtual Radiology Readings
Claims are submitted to the Blue Plan in the state the where the reading is being done. For example, if the virtual radiologist is located in Maine, the claims are submitted to Anthem BCBSME. Claims are processed based on the billing provider’s contractual relationship with the local Blue Plan.

Readmission to a facility within 30 days
We have a payment policy for 30 Day Readmission. The policy provides description, eligible and ineligible services and billing guidelines. Our payment policy for 30 Day Readmission is located on our non-secure provider website under Policies.

Robotic & Computer Assisted Surgery/Navigation
We have a payment policy for Robotic & Computer Assisted Surgery/Navigation. Our payment policy for Robotic & Computer Assisted Surgery/Navigation is located on our non-secure provider website under Policies.

Rural Health Center or Federally Qualified Health Center
We do not allow or recognize the UB04 billing for these designations. Claims for these provider types must be on a CMS 1500 form. The only exception is claims where Medicare is the primary carrier. See Section 6.6, “When Medicare Is a Primary Carrier” for claims submission specifics.

We do not recognize place of service 72 (a certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician) on a BCBSVT primary claim. If a place of service 72 is billed, the claim will be denied.

Specialty Pharmacy Claims
Claims submission guidelines for BlueCard®: Claims are to be submitted to the Plan in whose service area the ordering physician is located, as identified by the ordering provider identification number supplied in:
- Paper CMS 1500 form – item number 17b
- Electronic – 837 Loop 2310A

State Supplied Vaccine/Toxoid
The State supplied vaccine/toxoids must be submitted for data reporting purposes. Use the appropriate CPT code for the vaccine/toxoid and the modifier “SL” (state supplied vaccine) and a charge of $0.00*. If you submit through a vendor or clearinghouse that cannot accept a zero dollar amount, a charge of $0.01 can be used.

*claims for state supplied vaccines are required to be billed with the appropriate CPT code for the vaccine/toxoid and the modifier –SL with charges no greater than $0.01. If we receive a claim for state supplied vaccine/toxoids with a charge of $0.02 or greater, it will deny through the provider voucher stating “The vaccine service billed is greater than $0.01 and is included in the payment/allowance for another service/procedure.” A corrected claims will be required in order to complete the processing of the claim.

When BCBSVT is the primary carrier:

If the injected material** is not included on the claim and should be, the claim will be processed through the provider voucher requiring the correction of the claim.

The injectable material and administration* must be reported on the same claim, or a denial will occur.

**There is a 10-day look back on a claim submitted for an immunization administration for vaccine/toxoids codes 90460-90474. If there was a claim submitted within the 10-day window for the vaccine(s), the claim will process. If there is not a claim submitted within the 10-day window for the vaccine(s), the claim will deny.

If another Insurer is primary:

If the injected material is not included on the claim and should be, the claim may initially deny. If this occurs, you will need to contact the appropriate customer service team to have the claim adjusted.

Subsequent Hospital Care
Subsequent hospital care CPT codes (99231, 99232 and 99233) are “per day” services and need to be billed line by line.

Substance Use or Mental Health Disorder Trainee

Our Quality Improvement Policy, Supervised Practice of Mental Health and Substance Use Trainees provides the supervisor/trainee requirements and claim submission/coding requirements.

The policy is located on provider website under Policies, then the Quality Improvement link.

Supervised Billing
Also referred to as “incident to,” supervised billing is generally not allowed. Providers who render care to our members must be licensed, credentialed and enrolled. Exceptions are: Physical Therapy Assistants, Occupational Therapy Assistants and Mental Health Substance Use Disorder Trainees. Details on the requirements for Therapy Assistants and MH/SU Trainees are contained within this section.

Supplies
Submit using the appropriate CPT/HCPCS code. Charges submitted with an unspecified CPT code (99070) will be denied as non-covered for BCBSVT members.

Note: BlueCard® and FEP members may have benefits available. The members Blue Plan or FEP will determine the benefits.

**Surgical Assistant**

Benefits for one assistant surgeon may be provided during an operative session. In the event that more than one physician assists during an operative session, the total benefit for the assistant will not exceed the benefit for one. Please use appropriate CPT coding.

Not all surgeries qualify for a surgical assistant. To determine if the assist you are providing is eligible for consideration, use the Clear Claim Connection™ (C3) tool (details on how to use this tool are provided earlier in this handbook) on the secure provider website.

**Surgical Trays**

When billing for a surgical tray, bill HCPCS Level II Code A4550 along with the appropriate fee for the surgical tray. No modifiers or units are allowed.

Surgical tray benefits will only be considered when billed in conjunction with any surgical procedure for which use of a surgical tray is appropriate, when the procedure is performed in a physician’s office rather than a separate surgical facility.

To determine if a surgical tray is eligible for consideration, use the Clear Claim Connection™ (C3) tool (details on how to use this tool are provided earlier in this handbook) on the secure provider website. Enter in the services being performed along with the surgical tray code.

**Telemedicine**

We have a payment policy for telemedicine. The policy defines eligible telemedicine services and how the service needs to be billed. Our payment policy for telemedicine is located on our non-secure provider website under Policies.

Note: A BlueCard® member’s Blue Plan will determine the eligibility of telemedicine services.

Services provided via telemedicine that are not eligible per the payment policy; will process and deny non-covered, provider liable, but may be billed to the patient if the waiver requirements (located in this handbook) are met.

**Therapy (physical and occupational) 8 Minute Rule:**

Each 15-minute time-based CPT® code counts individually as one unit once the mid-point is passed *(8 or more minutes up to 22 minutes = 1 unit).* If less than 8 minutes is spent on any one of the 15-minute times codes, the 52 modifier should be added (reduced services). If the PT or OT provided 9 minutes of manual therapy (97140), that is past midpoint but not greater than 22 minutes and would allow for 1 unit of manual therapy to be billed. If the PT or OT provided 13 minutes of therapeutic activities (97530) that is past mid-point but not greater than 22 minutes and would allow for 1 unit of therapeutic activities to be billed. If the PT or OT provided 24 minutes of therapeutic exercise (97110), you have 15 minutes that will allow for the first unit therapeutic exercise. When you subtract those 15 minutes from
the entire 24 minutes of therapeutic exercise, this leaves 9 minutes. 9 minutes is past midpoint of a 15-minute time-based CPT code and would allow for a second unit of therapeutic exercise to be billed.

To summarize this exact example, the PT or OT would bill 1 unit of manual therapy, CPT® 97140 and 1 unit of therapeutic activities, CPT® 97530 and 2 units of therapeutic procedures/exercises, CPT® 97110.

A PHYSICAL THERAPY/MEDICINE SESSION IS DEFINED AS UP TO ONE HOUR OF SERVICES (treatment and/or evaluation) or up to three modalities provided on any given day. In any case billing for the three modalities cannot exceed one hour per session.

  Documentation for Constant Attendance Procedures/Modalities

When documentation supports constant attendance therapeutic procedures or modalities (i.e. 97110, 97112) are being performed; time documentation in minutes is required. The amounts of time versus the appropriate number of units to bill are as follows:

• If less than 8 minutes use modifier 52 for reduced services.
• If 8-22 minutes bill 1 unit.
• If 23-37 minutes bill 2 units, etc.

Transplant Services
If both the recipient and the donor have BCBSVT coverage, services need to be billed separately under each member’s BCBSVT coverage/ID.

If the recipient has BCBSVT and the donor has other insurance or is non-insured, services need to be billed under the donor name with the information from the recipient’s BCBSVT coverage/ID. These types of claims need to be submitted on paper.

Unit Billing for Room Charges on an Inpatient Stay
See Inpatient Stay - Unit Billing

Unit Designations
Each CPT and HCPCS code have a unit designation determined by us. The designation is single or multiple.

Single-Unit Codes
• You may only bill a code having a single-unit designation to us once, on one claim line indicating one unit. If you indicate more than one unit, we will deny*.
  o If you bill more than one claim line for a code with a single-unit designation, we will consider the first line for benefits and will deny all subsequent lines as duplicates to the first line.
Additionally, you must bill claim lines with a single-unit code as one unit, or we will deny* on the provider voucher for invalid units. You must resubmit claims we deny for invalid units as corrected claims.

*BCBSVT and FEP claims deny the line of the claim with the error, processing the remainder of the claim for consideration of benefit. BlueCard denies the entire claim.

Multiple-Units Codes

- You may only bill a code having a multiple-unit designation to BCBSVT as a single claim line with the amount of units indicated. If you bill multiple claim lines for a service with a multiple-unit designation, we will consider the first line for benefits and will deny all subsequent lines as duplicates to the first line. You must submit a corrected claim to increase the unit value of the first claim line if you need to bill more than one unit.

  See Medically Unlikely Units (MUE) information in this section for details on limits for multiple units and the program is administered.

A list of codes and their unit designations is available on our provider website under Provider Handbook and Resources, General Information.

The unit designation list is updated quarterly to align with the AMA’s updates for new, deleted and revised codes.

To request a review of a unit designation for a specific code, you must contact your provider relations consultant and provide the code along with any supporting documentation you have that supports a code should be more than one unit. A committee will review the request and, if the committee deems a unit designation change appropriate, it will be effective as of the date of the next quarterly CPT®/HCPCS adaptive maintenance cycle: January, April, July and October. The chart below provides the details on timing:

<table>
<thead>
<tr>
<th>If change in unit designation is approved the effective date will be</th>
<th>Request must be submitted by the date indicated to be considered for the review cycle</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1, XXXX</td>
<td>November 15</td>
</tr>
<tr>
<td>April 1, XXXX</td>
<td>February 15</td>
</tr>
<tr>
<td>July 1, XXXX</td>
<td>May 15</td>
</tr>
<tr>
<td>October 1, XXXX</td>
<td>August 15</td>
</tr>
</tbody>
</table>

Note: If a request is submitted after the given date, it will be carried to the next review cycle.

- For example: Request submitted November 20th. It will be considered for the April 1 effective date.
**Urgent Care Clinic**
We have a payment policy for Urgent Care Clinics. The policy defines what an urgent care clinic is (free standing or hospital-based) and how the services should be billed. Our payment policy for Urgent Care Clinic is located on our non-secure provider website under Policies.

**Vaccines**
See specific information above such as: COVID-19, Flu, Rabies or State Supplied
Section 6.7A

Anesthesia

Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient is safely placed under post-anesthesia supervision. Time that the anesthesiologist and/or certified registered nurse anesthetists (CRNAs) or anesthesia assistants (AAs) are not in personal attendance is considered non-billable time.

Services involving administration of anesthesia should be reported using the applicable anesthesia five-digit procedure codes (00100- 01999) and if applicable, the appropriate HCPCS National Level II anesthesia modifiers and/or anesthesia physical status (P1—P6) modifiers as noted below.

Anesthesia claims must be billed in minutes. See specific instructions below.

BCBSVT anesthesia codes are identified as CPT codes 00100 thru 01999, 99100, 99116, 99135, 99140 and HCPCS codes D9222, D9223, D9239 & D9243.

Anesthesia claims reported in minutes are rounded by BCBSVT to the first decimal position for pricing. If the second decimal position is greater or equal to 5, we round the first position up by 1.

- If = >5, we will add 1 to value in the first position after the decimal.
- If the second decimal position is less than 5, the decimal position remains as is.
- If <5, we leave the value in the first position unchanged.

<table>
<thead>
<tr>
<th>Example</th>
<th>Calculation</th>
<th>Rounded</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 minutes</td>
<td>61/15 = 4.066</td>
<td>4.1</td>
<td>00041</td>
</tr>
<tr>
<td>(See Ex. 1 below)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 minutes</td>
<td>17/15 = 1.133</td>
<td>1.1</td>
<td>00011</td>
</tr>
<tr>
<td>14 minutes</td>
<td>14/15 = .933</td>
<td>0.9</td>
<td>000091</td>
</tr>
<tr>
<td>147 minutes</td>
<td>147/15 = 9.80</td>
<td>9.8</td>
<td>00098</td>
</tr>
<tr>
<td>(See Ex. 2 below)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 minutes</td>
<td>38/15 = 2.533</td>
<td>2.5</td>
<td>00025</td>
</tr>
</tbody>
</table>

Example 1: 01780 BUV = 3 + 4.1 = 7.1*$49.67 = $352.66

Example 2: 01402 BUV =7 + 9.8 = 16.8*$49.67= $834.46

Anesthesia codes: 01953, 01996, 99100, 99116, 99135, 99140 time units are not a factor. Allowed amount will be calculated using ASA base unit values (BUVs) multiplied by anesthesia coefficient.
Example 01996 BUV = 3 multiplied by anesthesia coefficient $49.67—Allowed amount $149.01 (e.g., 3*$49.67 = $149.01).

BCBSVT requires the use of the following anesthesia modifiers when applicable. (Note: these modifiers must be billed in the first position of the modifier field):

- **-23**: Unusual anesthesia
  **Business Rule**: Medical Director review of operative notes and/or office notes are required. Payment based on the clinical information provided.

- **-47**: Anesthesia by surgeon
  **Business Rule**: Informational—Modifier use will not impact reimbursement.

- **-AA**: Anesthesia service performed personally by anesthesiologist
  **Business Rule**: Unusual circumstances when it is medically necessary for both the CRNA and anesthesiologist to be completely and fully involved during a procedure. Allows 100% of the fee schedule for each provider. Separate bills are required, Anesthesiologist reports –AA and CRNA reports –QZ.

- **-QK**: Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
  **Business Rule**: Anesthesiologist submits a separate bill from a qualified individual. Allows 50% of fee schedule payment based on the appropriate unit rate.

- **-QS**: Monitored anesthesia care services
  **Business Rule**: Informational—Modifier use will not impact reimbursement.

- **-QX**: CRNA service: with medical direction by a physician
  **Business Rule**: CRNA submits a separate bill from the anesthesiologist. Allows 50% of fee schedule payment based on the appropriate unit rate.

- **-QY**: Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
  **Business Rule**: Anesthesiologist submits a separate bill from the CRNA. Allows 50% of fee schedule payment based on the appropriate unit rate.

- **-QZ**: CRNA service: without medical direction by a physician
  **Business Rule**: Allows 100% of fee schedule payment based on the appropriate unit rate.

BCBSVT follows The Centers for Medicare and Medicaid Services (CMS) criteria for determination of Medical Direction and Medical Supervision.

**Medical Direction**
Medical direction occurs when an anesthesiologist is involved in a single anesthesia procedure with a qualified anesthetist or involved in two, three or four concurrent anesthesia procedures. The physician should:
1. Perform a pre-anesthesia examination and evaluation.
2. Prescribe the anesthesia plan.
3. Personally, participate in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable.
4. Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist.
5. Monitor the course of anesthesia administration at intervals.
7. Provide indicated post-anesthesia care.

If one or more of the above services are not performed by the anesthesiologist, the service is not considered medical direction.

Medical Supervision
Medical Supervision occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures. Medical supervision also occurs when the seven required services under medical direction are not performed by an anesthesiologist.

This might occur in cases when the anesthesiologist:

- Left the immediate area of the operating suite for more than a short duration;
- Devotes extensive time to an emergency case; or
- Was otherwise not available to respond to the immediate needs of the surgical patients.

Example: An anesthesiologist is directing CRNAs during three procedures. A medical emergency develops in one case that demands the anesthesiologist’s personal continuous involvement. If the anesthesiologist is no longer able to personally respond to the immediate needs of the other two surgical patients, medical direction ends in those two cases.

Medical Supervision by a Surgeon
In some small institutions, nurse anesthetist performance is supervised by the operating provider (i.e., surgeon) who assumes responsibility for satisfying the requirement found in the state health codes and federal Medicare regulations pertaining to the supervision of nurse anesthetists. Supervision services provided by the operating physician are considered part of the surgical service provided.

Anesthesia Physical Status Modifiers
These modifiers do not impact reimbursement. (Note: these modifiers are to be billed after all other modifiers are reported.

Examples:

QX modifier and a P1 modifier – the -QX must report in the first field and the -P1 in the second field

QK modifier, 22 modifier and a P5 modifier – the QK or a 22 modifier can be reported in either the first or second field and the P5 must report in the third field.

- **-P1**: A normal healthy patient.
- **-P2**: A patient with mild systemic disease.
- **-P3**: A patient with severe systemic disease.
- **-P4**: A patient with severe systemic disease that is a constant threat to life.
• **P5:** A moribund patient who is not expected to survive without the operation.
• **P6:** A declared brain-dead patient whose organs are being removed for donor purposes.

**Electronic Billing (837) of Anesthesia**
The appropriate indicator ‘MJ (minutes)’ must be used. Anesthesia claims are required to be billed in minutes. Please refer to our online 837 companion guides for electronic billing for specifics.

**Paper Billing of Anesthesia**
Report the amount of minutes in item number 24g – (field titled: days or units) on the CMS 1500 claim form.

**Dental Anesthesia**

*See the General Anesthesia billing instructions located earlier in this section for full details of how to bill for anesthesia.*

**Anesthesia claims must be billed in minutes.**

Below are the dental anesthesia services codes and how BCBSVT expects them to be billed:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D9222</td>
<td>Deep sedation/general anesthesia – first 15 minutes</td>
</tr>
<tr>
<td>D9239</td>
<td>Intravenous moderate (conscious) sedation/analgesia – first 15 minutes</td>
</tr>
<tr>
<td>D9223</td>
<td>Deep sedation/general anesthesia – each subsequent 15 minute increment</td>
</tr>
<tr>
<td>D9243</td>
<td>Intravenous moderate (conscious) sedation/analgesia – each subsequent 15 minute increment</td>
</tr>
</tbody>
</table>

Examples of how BCBSVT expects these services to be billed:

**Example 1:** Deep sedation/general anesthesia for 60 minutes (1 hour):

D9222 – 15 minutes (reported as 15 in 24g (paper billing) or MJ of 15 (electronic))

D9223 – 45 minutes (reported as 45 in 24g (paper billing) or MJ of 45 (electronic))

**Example 2:** Intravenous moderate (conscious) sedation/analgesia for 60 minutes (1 hour):

D9239 – 15 minutes (reported as 15 in 24g (paper billing) or MJ of 15 (electronic))

D9243 – 45 minutes (reported as 45 in 24g (paper billing) or MJ of 45 (electronic))

**Base Value of Dental Anesthesia**

D9223 & D9243 have a base value of “0” – as these codes do not have an anesthesia base value and allowance is determined using the number of minutes submitted on the claim.

D9222 & D9239 have a base value of “5”
Electronic Billing (837) of Anesthesia
The appropriate indicator ‘MJ (minutes)’ must be used. Anesthesia claims are required to be billed in minutes. Please refer to our online 837 companion guides for electronic billing for specifics.

Paper Billing of Anesthesia
Report the amount of minutes in item number 24g – (field titled: days or units) on the CMS 1500 claim form.

Notes:
- Not all BlueCard® members may have medical-dental benefits available to them. Coverage should be verified with the member’s Blue Plan. Stand-alone dental programs cannot be submitted through the BlueCard® program.
- FEP Blue Focus does not offer any dental coverage.
Section 6.7B
Modifiers

The modifiers below have certain requirements for BCBSVT submission or have specific payment rules.

1. Modifiers that are not listed as informational must be billed in the first position of the modifier field to process correctly.

   For example: If the service provided requires modifier 26 (professional component) or TC (technical component), and one or more other modifier(s), please be sure to put the 26 or TC in the first modifier position. This is required to ensure correct processing and reimbursement.

2. When billing site-specific modifiers, only one modifier can be billed per claim line.

   For example, if you are using both an LT and an RT modifier, two separate claim lines need to be reported. Claim lines containing more than one site specific modifier are denied through the provider voucher. A corrected claim needs to be submitted to correct the processing.

3. If a modifier has an impact on pricing, the service line it is reported on must be billed at the full charge*, without any reductions. Our processing system uses the billed charge as part of the calculation and if a reduction is already made, it will further reduce the allowance for the service.

   For example: modifier -82 (Assistant Surgeon when qualified resident surgeon not available) needs to have a billed amount that is the same as the primary surgeon’s fee.

   *we are defining “full charge” as the amount that would be billed if you were performing the complete procedure.

Even though a payment rate may be noted below, all services are still subject to all claim edits, logic and member benefits.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>BCBSVT Allowance and/or Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Services</td>
<td>BCBSVT has a specific payment policy for this modifier. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia</td>
<td>Medical Director review of operative notes and/or office notes. Payment based on the clinical information provided.</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.</td>
<td>Claims are subject to review if there is any question about the E/M being significant and separately identifiable. Office/clinical notes may be requested.</td>
</tr>
<tr>
<td>26</td>
<td>Professional Component (Utilized when charge for the physician component is reported separately.)</td>
<td>Reimbursement based on fee schedule for professional component only.</td>
</tr>
<tr>
<td>32</td>
<td>Mandated Services</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>47</td>
<td>Anesthesia by Surgeon</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
<td>50% of standard allowance. For bilateral surgical procedures when there is no specific bilateral procedure code, use the appropriate CPT code for the first service, and use the same code plus modifier -50 for the second service. The order in which services report on the claim does matter for pricing to be correct. The first line should not contain the modifier, the second line needs to contain the -50 modifier.</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures</td>
<td>50% of standard allowance amount for surgical procedures</td>
</tr>
<tr>
<td>52</td>
<td>Reduced Services</td>
<td>BCBSVT has a specific payment policy for this modifier. It is located on our non-secure provider website under Policie.</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>85% of standard allowed amount for surgical procedure</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Management Only</td>
<td>10% of standard allowance amount for surgical procedure.</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative Management Only</td>
<td>5% of standard allowed amount for surgical procedure.</td>
</tr>
<tr>
<td>57</td>
<td>Decision for Surgery</td>
<td>BCBSVT does not provide benefits for decision for surgery.</td>
</tr>
<tr>
<td></td>
<td>Description</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>58</td>
<td>Staged or Related Procedure or Service by the Same Physician During the Postoperative Period</td>
<td>Submitting modifier 59 with a procedure indicates that a distinct procedural service was performed, separate from other services rendered on the same day by the same provider. Modifier 59 should only be used when no other valid modifier (e.g., site-specific) applies. For use of modifier 59, the medical record must clearly indicate the circumstances for reporting in this manner. Office/clinical notes may be requested.</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td></td>
</tr>
<tr>
<td>62</td>
<td>Two Surgeons</td>
<td>When medical records are submitted with the claim, we allow up to 150% of the standard allowance, evenly divided between the two co-surgeons. If the records clearly identify the chief surgeon, we split the reimbursement accordingly—100% chief surgeon/50% second surgeon) -or- If no medical records (operative/office notes) are submitted with the claim, we process the claims to pay each surgeon at 75% of the standard allowance.</td>
</tr>
<tr>
<td>63</td>
<td>Procedure Performed on Infants less than 4 kgs</td>
<td>Informational—Modifier use will not impact reimbursement</td>
</tr>
<tr>
<td>66</td>
<td>Surgical Team</td>
<td>When medical records are submitted with the claim, we allow up to 200% of the standard allowance evenly divided between 2 team surgeons. If the medical record clearly identifies a chief surgeon, the reimbursement is split as follows: 100% chief surgeon 50% to each additional surgeon OR If NO medical records (operative/office notes) are submitted with the claim, we deny the claim back to the provider requesting operative/office notes.</td>
</tr>
<tr>
<td>76</td>
<td>Repeat Procedure by Same Physician</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>77</td>
<td>Repeat Procedure by Another Physician</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>78</td>
<td>Return to the Operating Room for a Related Procedure During the Postoperative Period.</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated Procedure or Service by the Same Physician During the Postoperative Period</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td>Allowed only when a surgical assistant assists for the ENTIRE surgical procedure. Medical records must support the attendance of the assist from the beginning of the surgery until the end of the procedure. 25% of S.A. amount for primary surgical procedure. 12.5% of the standard allowance for each secondary procedure.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td>We only allow when the surgical assist is present for a part of the surgical procedure. 10% of S.A. amount for primary surgical procedure. 5% of the standard allowance for each secondary procedure.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon (when qualified resident surgeon not available)</td>
<td>We only allow when a surgical assistant assists for the ENTIRE surgical procedure. Medical records must support the attendance of the assist from the beginning of the surgery until the end of the procedure. 25% of S.A. amount for primary surgical procedure. 12.5% of the standard allowance for each secondary procedure.</td>
</tr>
<tr>
<td>90</td>
<td>Reference (outside) Laboratory</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>91</td>
<td>Repeat Clinical Diagnostic Laboratory Test</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>96</td>
<td>Habilitative Services</td>
<td>When providing habilitative services for physical medicine, occupational or speech therapy a modifier 96 must be reported for services to accumulate to the correct benefit level.</td>
</tr>
<tr>
<td>97</td>
<td>Rehabilitative</td>
<td>Informational – modifier will not impact reimbursement</td>
</tr>
<tr>
<td>----</td>
<td>----------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>99</td>
<td>Multiple Modifiers</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>AA</td>
<td>Anesthesia service performed personally by anesthesiologist</td>
<td>Unusual circumstances when it is medically necessary for both the CRNA and anesthesiologist to be completely and fully involved during a procedure, 100% payment for the services of each provider is allowed. Anesthesiologist would report –AA and CRNA-QZ.</td>
</tr>
<tr>
<td>AS</td>
<td>Physician’s assistant, nurse practitioner or clinical nurse specialist services for assistant surgery.</td>
<td>We only allow when a surgical assistant assists for the ENTIRE surgical procedure. Medical records must support the attendance of the assist from the beginning of the surgery until the end of the procedure. 25% of S.A. amount for primary surgical procedure 12.5% of the standard allowance for each secondary procedure.</td>
</tr>
<tr>
<td>AU</td>
<td>Item furnished in conjunction with a urological, ostomy, or tracheostomy supply</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>AV</td>
<td>Item furnished in conjunction with a prosthetic device, prosthetic or orthotic</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>AW</td>
<td>Item furnished in conjunction with a surgical dressing</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>AX</td>
<td>Item furnished in conjunction with dialysis services</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>EY</td>
<td>No physician or other licensed health care provider ordered for this item or service</td>
<td>See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>FY</td>
<td>X-ray taken using computed radiography technology/cassette-based imagining</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
</tbody>
</table>
| GY | Item or service statutorily excluded does not meet the definition of any Medicare benefit for non-Medicare | CANNOT BE USED WHEN THERE IS A MEDICARE REPLACEMENT SUCH AS A MEDICARE ADVANTAGE PLAN AS PRIMARY. The GY modifier allows our system to recognize that the service or provider is statutorily excluded and to bypass the Medicare explanation of payment requirement. The GY modifier can only

[117] Provider Handbook Version 8.2 – August 1, 2021
Insurers, and is not a contracted benefit. be used when submitting claims for Medicare members when the service or provider is statutorily excluded by Medicare.*

In addition to the GY modifier, the claim submission (paper or electronic) must indicate that Medicare is the member’s primary carrier.

Our processing system has the ability to edit on the proper use and reporting of the modifier GY. If it is not appropriately used, the claim will deny back on the provider voucher and appropriate actions will need to be taken with the claim.

BlueCard® claims:

If a GY modifier is used, it must be submitted directly to BCBSVT. The submission of these claims to BCBSVT allows us to apply your contracted rate so the claims will accurately process according to the member’s benefits.

Claims that cross over to another Blue Plan from Medicare and contain services with a GY modifier will not be processed by the member’s Blue Plan. Instead, either a letter or provider voucher denial will be issued alerting you that the claim must be submitted to your local Plan, BCBSVT. We do this so that our local Plan pricing is applied. Services without the GY process using Medicare’s allowance; services with the GY need our pricing.

When submitting previously processed Medicare claims directly to BCBSVT, include the original claim (with all lines, including those without the GY modifier) and the Explanation of Medicare Benefits. Lines that have previously paid through the member’s Blue Plan will deny as duplicate and the lines with the GY modifiers will be processed according to the benefits the member has available.

*NOTE: BCBSVT members with a supplemental plan (typically have a prefix of ZIB) do not have benefits available in the absence of Medicare coverage.

<p>| GZ | Item or services expected to be denied as not reasonable and necessary | Informational—Modifier use will result in no reimbursement for service rendered and billed with modifier GZ. See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies. |</p>
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HO</td>
<td>Master’s degree level</td>
<td>Informational – Modifier use will not impact reimbursement. Used when supervising trainee – see section on Mental Health Substance Use Disorder Trainee.</td>
</tr>
<tr>
<td>HP</td>
<td>Doctoral level</td>
<td>Informational – Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>JG</td>
<td>Drug or biological acquired with 340b drug pricing program discount</td>
<td>Informational – Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>KS</td>
<td></td>
<td>See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>KX</td>
<td></td>
<td>See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
<td>Informational—Modifier use will not impact reimbursement. See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals</td>
<td>Allows 50% of fee schedule payment based on the appropriate unit rate.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-------</td>
</tr>
<tr>
<td>QS</td>
<td>Monitored anesthesia care services</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>QT</td>
<td>Recording and storage on tape by an analog tape recorder</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>QW</td>
<td>CLIA waived test</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
<td>Allows 50% of fee schedule payment based on the appropriate unit rate.</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.</td>
<td>Allows 50% of fee schedule payment based on the appropriate unit rate.</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service, without medical direction by a physician</td>
<td>Allows 100% of fee schedule payment based on the appropriate unit rate.</td>
</tr>
<tr>
<td>RA</td>
<td>Replacement of a DME, orthotic or prosthetic item</td>
<td>Informational—Modifier use will not impact reimbursement. See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>RR</td>
<td>Rental (use RR modifier when DME is being rented)</td>
<td>Rental reimbursement applies when billed. See below for billing expectations. See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>SL</td>
<td>State-supplied vaccine</td>
<td>Allows $0.00. See detailed instructions below.</td>
</tr>
<tr>
<td>TB</td>
<td>Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
<td>Reimbursement based on fee schedule for technical component only.</td>
</tr>
<tr>
<td>UE</td>
<td>Used Durable Medical Equipment</td>
<td>Reimbursement based on fee for used equipment (fee less than that of purchase price). See payment policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for full details. It is located on our non-secure provider website under Policies.</td>
</tr>
<tr>
<td>X1</td>
<td>Continuous/broad services: for reporting services by clinicians, who provide the principal care for a patient, with no planned endpoint of the relationship; services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role; reporting clinician service examples include, but are not limited to primary care, and clinicians providing comprehensive care to patients in addition to specialty care</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>X2</td>
<td>Continuous/focused services: for reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed with no planned endpoint to the relationship; reporting clinician service examples include but are not limited to a rheumatologist taking care of the patient's rheumatoid arthritis longitudinally but not providing general primary care services</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>X3</td>
<td>Episodic/broad services: for reporting services by clinicians who have broad responsibility for the comprehensive needs of the patient that is limited to a defined period and circumstance such as a</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Notes</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>X4</td>
<td>Hospitalization; reporting clinician service examples include but are not limited to the hospitalist's services rendered providing comprehensive and general care to a patient while admitted to the hospital</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>X4</td>
<td>Episodic/focused services: for reporting services by clinicians who provide focused care on particular types of treatment limited to a defined period and circumstance; the patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention; reporting clinician service examples include but are not limited to, the orthopedic surgeon performing a knee replacement and seeing the patient through the postoperative period</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>X5</td>
<td>Diagnostic services requested by another clinician: for reporting services by a clinician who furnishes care to the patient only as requested by another clinician or subsequent and related services requested by another clinician; this modifier is reported for patient relationships that may not be adequately captured by the above alternative categories; reporting clinician service examples include but are not limited to the radiologist's</td>
<td>Informational—Modifier use will not impact reimbursement.</td>
</tr>
<tr>
<td>interpretation of an imaging study requested by another clinician</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.7C

Immunization Administration

CPT codes 90460 and 90461 should only be reported when a physician or other qualified health care professional provides face-to-face counseling to the patient and family during the administration of a vaccine. This face-to-face encounter needs to be clearly documented to include scope of counseling and who provided counseling (include title[s]) to patient and parents/caregiver. Proper signatures are also required to verify level of provider qualification. Documentation must be stored in the patient’s medical records.

Qualified health care professional does not include auxiliary staff, such as licensed practical nurses, nursing assistants, and other medical staff assistants.

Each vaccine is administered with a base (CPT 90460) and an add-on code (CPT 90461) when applicable. CPT codes 90460 and 90461 allow for billing of multiple units when applicable.

**Single Line Billing Examples with Counts**

**Example A:** Single line billing, multiple vaccines with combination toxoids

<table>
<thead>
<tr>
<th>Line</th>
<th>CPT-4</th>
<th>Description</th>
<th>Unit Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>90649</td>
<td>Human papilloma virus vaccine quadriv 3 dose</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>im</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>90460</td>
<td>Immunization Administration18 yr any route 1st</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>vac/toxoid</td>
<td></td>
</tr>
</tbody>
</table>

**Example B:** Single line billing, multiple vaccines with combination toxoids

<table>
<thead>
<tr>
<th>Line</th>
<th>CPT-4</th>
<th>Description</th>
<th>Unit Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>90710</td>
<td>Measles mumps rubella varicella vaccine live</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>subq</td>
<td></td>
</tr>
<tr>
<td>Line</td>
<td>CPT-4</td>
<td>Description</td>
<td>Unit Count</td>
</tr>
<tr>
<td>------</td>
<td>---------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>1</td>
<td>90698</td>
<td>Dtap-ipv vaccine im</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>90670</td>
<td>Pneumococcal conj vaccine 13 valent im</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>90680</td>
<td>Rotavirus vaccine pentavalent 3 dose live oral</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>90460</td>
<td>Immunization Administration through 18 yrs any route 1st vaccine/toxoid</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>90461</td>
<td>Immunization Administration through 18 yrs any route ea. additional vaccine/toxoid</td>
<td>4</td>
</tr>
</tbody>
</table>

Example C: Single line billing, multiple vaccines with combination toxoids

If a patient of any age presents for vaccinations, but there has been no face-to-face counseling, the administration(s) must be reported with codes 90471–90474.

Use the appropriate CPT code for administration of the injection. If applicable, submit the appropriate CPT and/ or HCPCS code for the injected material.

**When BCBSVT is the primary carrier:**

If the injected material* is not included on the claim and should be, the claim will be processed through the provider voucher requiring the correction of the claim.

The injectable material and administration* must be reported on the same claim, or a denial will occur.

*There is a 10-day look back on a claim submitted for an immunization administration for vaccine/toxoids codes 90460-90474. If there was a claim submitted within the 10-day window for the vaccine(s), the claim will process. If there is not a claim submitted within the 10-day window for the vaccine(s), the claim will deny.
If another Insurer is primary:

If the injected material is not included on the claim and should be, the claim may initially deny. If this occurs, you will need to contact the appropriate customer service team to have the claim adjusted.

There is a known defect with the National Correct Coding Initiative (NCCI) when billing a Immunization Administration (90460 or 90461) service and a Health Risk Assessment (96160 or 96161) on the same day for the same patient or billed under the same patient. The Health Risk Assessment denies inclusive to the Immunization Administration.

In order for both services to be considered for benefits, the edit must be bypassed by appending a modifier 59 to the Health Risk Assessment service. We understand that this is a coding violation under NCCI edits, but the modifier is necessary to “break” the NCCI code and have the claim process correctly.
Section 6.7D

Mammogram Screening and Screening Additional Views

Members age 50+ can self-refer for mammogram screenings.

We have very specific coding requirements for screening mammograms and screening additional views (“screening call backs”) with a Breast Imaging Report and Data System (BI-RADS) score of 0 (zero).

For an initial mammography that is a screening mammography, the following coding will process at no member cost share*:

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Primary ICD-10 Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>77063, 77067</td>
<td>Z00.00, Z00.01, Z12.31, Z12.39, Z80.3, Z85.3, Z90.10, Z90.11, Z90.12, Z90.13</td>
</tr>
<tr>
<td>(Append modifier -52 for unilateral exam)</td>
<td></td>
</tr>
</tbody>
</table>

For additional views or “call backs” if the initial screening mammography resulted in a BI-RADS 0 exam the following CPT ® & ECD 10-CM will be used and shall process at no member cost share. No modifier is necessary to indicate screening.

<table>
<thead>
<tr>
<th>CPT/HCPCS Code</th>
<th>Primary ICD-10 Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>76641, 76642, 77061, 77062, 77063, 77065, 77066, 77067, G0279</td>
<td>R92.2, R92.8</td>
</tr>
<tr>
<td>(Append modifier -52 to report a unilateral exam)</td>
<td></td>
</tr>
</tbody>
</table>

Please also note that the date of service may be same day or a subsequent date if there is an additional mammogram or ultrasound required to complete the screening examination. Examinations of the breast by other modalities may have cost share.

While the national preventive care guidelines recommend screening mammography everyone to two years, BCBSVT does not require that members wait at least 365 days between medically necessary, screening mammograms to access first-dollar coverage**.
*When applicable. Member must have a benefit program that includes the Affordable Care Act, first dollar preventive benefits.

**When applicable. Member must have a benefit program that includes the Affordable Care Act, first dollar preventive benefits.

The Federal Employee Program and BlueCard benefits may not provide first-dollar coverage. For details on eligible mammography services, contact the appropriate customer service team or Blue Plan.
Section 6.7E

Informational Only Codes

CPT (Category II xxxxF)/HCPCS codes considered investigational only and reimbursement is not provided, specific codes are listed below:

Category II Codes (xxxxF): 0005F -9007F

G-Codes Ranges:
- Quality Measures G0913 – G0918, G8395 - G8976,
- Functional Limitation G8978-G8999,
- Coordinated Care G9001 – G9012
- Demonstration Project G9013 - G9140,
- Quality Assurance G9148 – G9153,
- Functional Limitation G9158-G9186,
- BPCI Services G9187
- Miscellaneous Quality Measures G9188 – G9472
- Medicare Care Choice Model Program G9480
- CMS Innovation Center Demonstration Project G9481 – G9490
- Quality Measures G9497 – G9523
- Hospice Care G9524 – G9526
- Blunt Head Trauma G9529 – G9537
- Miscellaneous Quality Measures G9539 – G9560
- Opiate Therapy G9561 – G9579
- Stroke Therapy G9580 – G9582
- Opiate Therapy G9583 – G9585
- Blunt Head Trauma G9593 – G9597
- Aortic Aneurysm G9598 – G9600
- Discharge to Home G9601 – G9602
- Patient Survey G9603 – G9605
- Intraoperative Cystoscopy G9606 – G9608
- Aspirin/Antiplatelet Therapy G9609 – G9611
- Colonoscopy Documentation G9612 – G9614
- Preoperative Assessment G9615 – G9617
- Uterine Malignancy Screening G9618 – G9620
- Alcohol Use G9621 – G9624
- Bladder/Ureter Injury G9625 – G9633
- Health-Related Quality of Life G9634 – G9636
- Quality Measures G9637 – G9648
- Psoriasis Therapy G9649 – G9651
- Anesthesia Services G9654 – G9658
- Reason for Colonoscopy G9659 – G9661
- Statin Therapy G9662 – G9666
- Cardiovascular Measures G9674 – G9676
- Oncology Demonstration Project G9678
- Nursing Facility Care G9683, G9685 (these services are for a demonstration project)
- Other Quality Measures G9687 – G9987
- **M-Codes Ranges:**
- **Quality Measures** M1000 – M1071
Section 6.7F

Dental Care

**FEP members** with Standard or Basic Option products have limited dental care available through the medical coverage and also have a supplemental dental policy available to them at an additional cost. To learn more about FEP dental coverage and claim submission requirements, refer to the FEP Section of this handbook.

**BlueCard claims** – dental claims and ADA dental forms are excluded from processing through the BlueCard program. Claims must be submitted to the appropriate Plan for consideration. If the services are for Medical Dental, they must be submitted on a CMS1500 form and will be processed through the BlueCard program.

**BCBSVT members** who are eligible:

- Federally Qualified Health Plans, identified by a prefix of “ZII” or “ZIG” have benefits available for pediatric dental, if they are age 21 or under. Dental coverage is provided through the end of the year of their 21st birthday.
- Administrative Services Only (ASO) whose employer group has purchased dental coverage through the BCBSVT Dental Medical Policy.

The BCBSVT Dental Medical Policy defines eligible services, prior approval requirements and where claims are to be submitted. It has two sections; Part A and Part B.

- Part A defines the services and requirements of the medical components for dental. The Part A benefits are administered by BCBSVT and require the use of a BCBSVT-contracted provider. Prior approval requests and claim submission are sent directly to BCBSVT.
- Part B defines the services and requirements for the pediatric dental benefits. The Part B benefits are administered by CBA Blue and require the use of CBA Blue-contracted providers. Prior approval and claim submissions are sent directly to CBA Blue.

**Note:**

- CBA Blue responds to provider inquiries on dental services and claims related to Part B, and BCBSVT responds to member inquiries related to Part A. Pre-treatment or prior approval forms submitted to CBA Blue are responded to by CBA Blue using BCBSVT letterhead.
- If services incorporate both Part A and Part B services and prior approval is required, the prior approval needs to be submitted to BCBSVT. We will coordinate with CBA Blue for proper processing. Claims can be and sent to both, or if that is not possible, you may submit directly to BCBSVT and we will coordinate the processing.
This section is to clarify dental contracts, claim processing, customer service and eligibility verification.

**Blue Cross and Blue Shield of Vermont Policies**

All BCBSVT members have coverage for medical dental services as defined in our on-line Dental Medical Policy. For these benefits:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract/Network Required</td>
<td>Blue Cross and Blue Shield of Vermont contract</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>BCBSVT</td>
</tr>
<tr>
<td></td>
<td>Electronic: Payer ID BCBSVT or SB915</td>
</tr>
<tr>
<td></td>
<td>Paper: Fax (866) 334-4232 or email <a href="mailto:claims@bcbsvt.com">claims@bcbsvt.com</a></td>
</tr>
<tr>
<td>Customer Service and Member eligibility</td>
<td>BCBSVT</td>
</tr>
<tr>
<td></td>
<td>Phone: (800) 924-3494</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:customerservice@bcbsvt.com">customerservice@bcbsvt.com</a></td>
</tr>
</tbody>
</table>

BCBSVT policies that are for Federally Qualified Health Plans (prefix ZII and ZIG) have benefits available for pediatric dental if the members are aged 21 or under. The benefits are defined in our on-line Dental Medical Policy. There are also some Administrative Services Only employer groups that have purchased dental coverage through BCBSVT. For these benefits:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract/Network Required</td>
<td>CBA Blue</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>CBA Blue</td>
</tr>
<tr>
<td></td>
<td>Electronic: Payer ID 03036</td>
</tr>
<tr>
<td></td>
<td>Paper: PO Box 9350, South Burlington, VT  05407-9350</td>
</tr>
<tr>
<td>Customer Service and Member eligibility</td>
<td>CBA Blue</td>
</tr>
<tr>
<td></td>
<td>Phone: (888) 222-9206 option 3 then 2</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:service@cbabluvevt.com">service@cbabluvevt.com</a></td>
</tr>
</tbody>
</table>

**BlueCard® Program**

The BlueCard® Program enables members living or traveling in another Blue Plan service area to obtain healthcare benefits.

Stand-alone dental – dental services billed on an ADA claim form are excluded from the BlueCard® Program.

Medical dental services are available through some plans; you will need to verify eligibility prior to rendering services. For these benefits:
### Federal Employee Program

FEP members with a Basic or Standard Options policy have medical benefit coverage that provides benefits for select procedures that are identified under the Schedule of Dental Allowance and Maximum Allowance Charges (MAC). For a copy of the MAC, please email providerrelations@bcbsvt.com. For these benefits:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract/Network Required</td>
<td>Blue Cross and Blue Shield of Vermont contract</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>BCBSVT</td>
</tr>
<tr>
<td></td>
<td>Electronic: Payer ID BCBSVT or SB915</td>
</tr>
<tr>
<td></td>
<td>Paper: Fax (866) 334-4232 or email <a href="mailto:claims@bcbsvt.com">claims@bcbsvt.com</a></td>
</tr>
<tr>
<td>Customer Service and Member eligibility</td>
<td>BCBSVT</td>
</tr>
<tr>
<td></td>
<td>Phone: (800) 328-0365</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:fepcustomerservice@bcbsvt.com">fepcustomerservice@bcbsvt.com</a></td>
</tr>
</tbody>
</table>

### Federal Employee Program - Continued

FEP members can purchase a dental supplemental benefit, FEP BlueDental. Members who have purchased FEP BlueDental have a separate identification card. For these benefits:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract/Network Required</td>
<td>CBA Blue</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>CBA Blue</td>
</tr>
</tbody>
</table>
**Vermont Blue Advantage**

There are two different benefits for members for dental services: the traditional services covered under Medicare and enhanced benefits available through a Medicare Advantage plan such as Vermont Blue Advantage.

**Traditional Medicare Dental Benefits**

Please visit the CMS.gov website under Local Coverage Article: Billing and Coding DENTAL Services (A56663) for the details of services eligible under this benefit. Here is what the link is:

Link: https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=56663&ver=6&KeyWord=dental&KeyWordLookUp=Title&KeyWordSearchType=Exact&bc=CAAAAAAA

For these benefits:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract/Network Required</td>
<td>Blue Cross and Blue Shield of Vermont contract that includes a Medicare Advantage Addendum</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>VBA</td>
</tr>
<tr>
<td></td>
<td>Electronic: submit to BCBSVT as usual and we will forward</td>
</tr>
<tr>
<td></td>
<td>Paper: VBA, PO Box 260755, Planto, TX 75026</td>
</tr>
<tr>
<td>Customer Service and Member eligibility</td>
<td>VBA</td>
</tr>
<tr>
<td></td>
<td>Phone: (844) 839-5112</td>
</tr>
</tbody>
</table>

**Vermont Blue Advantage - Continued**

**Enhanced Dental Benefit**

Eligible services include but may not be limited to cleanings, fillings, root canals, etc. Please contact DentaQuest for full details. For these benefits:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract/Network Required</td>
<td>United Concordia</td>
</tr>
</tbody>
</table>
(877) 438-8224 go through prompts as a provider then ask to speak with Provider Relations (no direct line to this area)

| Claim Submission | DentaQuest  
Electronic: if using a clearinghouse BBMDQ  
On-Line: provideraccess.dentaquest.com  
Paper: DentaQuest, PO Box 491, Milwaukee, WI 53201-0491 |
|------------------|--------------------------------------------------|
| Customer Service and Member eligibility | DentaQuest  
(800) 936-0941 |
Section 7

The BlueCard® Program

As a participating provider of BCBSVT, you must render services to patients who are national account members of other Blue Cross and/or Blue Shield Plans, and who travel or live in Vermont.

This section is designed to describe the advantages of the program, while providing you with information to make filing claims easy. This section offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Whom to contact with questions

What Is the BlueCard® Program?

The BlueCard® program is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan’s service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program allows you to submit claims for patients from other Blue Plans, domestic and international, to BCBSVT and receive processing and/or payments directly.

BCBSVT is your sole contact for claims payment, problem resolution and adjustments.

Accounts Exempt from the BlueCard® Program

The following claims are excluded from the BlueCard® Program:

- Stand-alone dental – dental billed on an ADA claim form – see section 6.7F for details
- Vision delivered through an intermediary model (using a vendor)
- Prescription drugs delivered through an intermediary model (using a vendor)
- Medicare and SCHIP products that are part of a state’s Medicaid program
- The Federal Employee Program (FEP)
How to Identify Members

**Member ID Cards:** When members of another Blue Plan arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

The main identifier for out-of-area members is the alpha prefix. The alpha prefix identifies the Blue Plan or national account to which the member belongs. It is critical for confirming a patient’s membership and coverage.

Important facts concerning member IDs:

- A correct member ID number includes the alpha prefix (first three positions, typically alpha format).
- The information following the alpha prefix can be any length, and can consist of all numbers, all letters or a combination of both letters and numbers, and is the rest of the member ID.

This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the alpha prefix.

- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Some Blue Plans issue separate identification numbers to members with Blue Cross (Facility) and Blue Shield (Professional) coverage. Member ID cards may have different alpha prefixes for each type of coverage.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient’s file.
- Make copies of the front and back of the member’s ID card and pass the key information on to your billing staff.

**Medicaid ID Cards:** Members enrolled in a Blue Medicaid product are issued Blue Plan ID cards. These ID cards will not contain a suitcase logo, however, claims are submitted and processed through BlueCard®. Please note that the state’s Medicaid rules and limitations will apply. You may have to be registered with the Blue Plan in order to submit claims.

**Identification Cards/Foreign Identification Cards:** Occasionally, you may see identification cards from Blue members residing abroad or foreign Blue members. These ID cards also contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.
Consumer Directed Health Care and Health Care Debit Cards: Consumer Directed Health Care (CDHC) is a term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate health care decision through the use of member support tools, provider and network information, and financial incentives.

Members who have CDHC plans often have health care debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member’s employer to pay for eligible expenses not covered by the health plan.

Some cards are “stand-alone” debit cards to cover out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt.
- Reduce paperwork for billing statements.
- Minimize bookkeeping and patient-account functions for handling cash and checks.
- Avoid unnecessary claim payment delays.

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

The cards include a magnetic strip so providers can swipe the card at the point of service to collect the member cost-sharing amount (i.e. copayment). With health debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member’s appropriate HRA, HSA or FSA account.

If your office accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

Helpful Tips:

- Carefully determine the member’s financial responsibility before processing payment. You can access the member’s eligibility, benefits and accumulated deductible/benefit totals by contacting the BlueCard® Eligibility line at (800) 676-BLUE (2583) or by using the BCBSVT online, real-time transaction.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out-of-pocket amounts before processing payment:
  - You may use the debit card for member responsibility for medical services provided in your office.
  - You may choose to forego using the debit card and submit the claims to BCBSVT for processing. The provider voucher will inform you of member responsibilities.
- All services, regardless of whether or not you’ve collected the member responsibility at the time of service, must be billed to the local Plan (please review billing requirements as ancillary
providers have separate billing instructions) for proper benefit determination, and to update the member’s claim history.

Please do not use the card to process full payment up front. If you have any questions about the member’s benefits, please contact (800) 676-BLUE (2583). For questions about the health care debit card processing instructions or payment issues, please contact the toll-free debit card administrator’s number on the back of the card.

*Coverage and Eligibility Verification*

Verifying eligibility and confirming the requirements of the member’s policy before you provide services is essential to ensure complete, accurate and timely claims processing.

Each Blue Cross and Blue Shield Plan has its own terms of coverage and medical policies. There may be exclusions or requirements you are not familiar with. Each plan may also have a different copayment application that is based on provider specialty. For example, a visit with a nurse practitioner or physician assistant in a primary care practice setting may apply a specialist copayment rather than a PCP copayment. Some Blue Plans may exclude the use of certain provider specialties such as naturopath, acupuncture or athletic trainers. Some members may have only Blue Cross (Inpatient) or only Blue Shield (Professional) coverage with their Blue Plan, so verifying eligibility is extremely important. There are two methods of verification available:

- Electronic: Submit an electronic transaction via the tool located on the Provider Resource Center.
- Phone: Call BlueCard® Eligibility (800) 676-BLUE (2583).
  - You will need to input the alpha prefix to connect you to the membership and coverage unit at the patient’s Blue Cross and/or Blue Shield Plan.
  - If you are using the BlueCard® Eligibility line, keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than Vermont. You may be transferred to a voice response system linked to customer enrollment and benefits.
  - The BlueCard® Eligibility line is for eligibility, benefit and pre-certification inquiries only. It should not be used for claim status. See the Claim Filing section for claim filing information.

*Utilization Review*

BCBSVT participating facilities are responsible for obtaining approval for inpatient services for BlueCard® members. Each Blue Plan may call it something different such as pre-service, prior approval, or pre-certification review. Regardless of what each Blue Plan calls it, members are held harmless when review of an inpatient stay is required and not obtained. Participating facilities must also:

- Notify the member’s Blue Plan within 48 hours when a change or modification to the original inpatient approval occurs.
• Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member’s Blue Plan for pre-service/prior approval/precertification review or for a change of modification of the pre-service review may result in a denial for inpatient facility services. The provider voucher reports the service as a provider write-off and the BlueCard® member must be held harmless and cannot be balance-billed if a pre-service/prior approval/pre-certification review was not obtained.

On inclusively priced claims such as DRG or Per Diem, billing more days than were authorized may result in the full claims being denied in some instances.

Services that deny as not medically necessary remain provider liability.

Pre-service review contact information for a member’s Blue Plan is provided on the member’s identification card. Pre-service review requirements can also be determined by:

• Calling the pre-admission review number on the back of the member’s card.
• Calling the customer service number on the back of the member’s card and asking to be transferred to the utilization review area.
• If you do not have the member’s card, calling (800) 676-BLUE (2583) and asking to be transferred to the utilization review area.
• Using the Electronic Provider Access (EPA) tool available at the BCBSVT Provider Resource Center.
  o With EPA, you can gain access to a BlueCard® member’s Blue Plan through a secure routing mechanism and have access to electronic pre-service review capabilities. Note: the availability of EPA will vary depending on the capabilities of each member’s Blue Plan.

Claim Filing

Submit all Blue claims to BCBSVT* following the BCBSVT paper claim submission or the 837 companion guidelines. These are available on our Provider Resource Center. Specific claim submission requirements for BCBSVT are provided later in this handbook.

• Paper claims: P.O. Box 186, Montpelier, VT 05601
• Electronic: Using a HIPAA-compliant 837 form to receive identification “BCBSVT.”

*There are some circumstances in which claims may not be submitted to BCBSVT:

• Providers who render services in contiguous counties, contract with other Blue Plans or have secondary locations outside the State of Vermont may not always submit directly to BCBSVT.
  o There are three guides (Vermont and New Hampshire, Vermont and Massachusetts, Vermont and New York) to assist you in determining where to submit claims in these circumstances. These guides are located on our provider website at bcsvt.com/provider/reference-guides.
• Ancillary type providers (defined as Durable Medical Equipment, Independent Clinical Laboratory and Specialty Pharmacy) have special billing instructions located later in this
handbook. Please refer to those instructions as not all claims for these types of providers are submitted to BCBSVT.

- Medicare adjusted claims must be submitted directly to the member’s Blue Plan.
- Medicare Advantage or Vermont Blue Advantage paper claims.

**Reminder:** It is important to include the member’s complete identification number. This includes the three-character alpha prefix (prefixes must be in capital letters). Submit claims with only valid alpha-prefixes (they must be reported as capital letters); claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.

### How Claims Flow Through BlueCard®

1. Member of another Blue Plan receives services from you, the provider.
2. Provider submits claim to local Blue Plan.
3. Local Blue Plan recognizes BlueCard member and transmits standard claim format to the member’s Blue Plan.
4. Member’s Blue Plan adjudicates the claim according to the member’s benefit plan.
5. Member’s Blue Plan issues an Explanation of Benefits to the member.
6. Member’s Blue Plan transmits claim payment disposition to your local Blue Plan.
7. Your local Blue Plan pays you, the provider.

Your local Blue Plan reports to you the processing on a provider voucher and, if applicable, provides payment.

**Reminders:**

- Do not send duplicate claims.
- Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member as they will receive multiple EOB’s.
- Do not send corrected/late claims until you receive the original claim processing on a provider voucher.
• Check claims status by contacting BCBSVT at (800) 395-3389 or using the online claim status tool at www.bcbsvt.com.

Medicare Advantage Overview

“Medicare Advantage” (MA) is the alternative to the program that is often referred to as “traditional Medicare” — standard Medicare Part A and Part B fee-for-service coverage.

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All MA plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, MA organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

MA plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by calling (800) 676.BLUE (2583) or submitting an electronic inquiry for all Medicare Advantage members prior to providing service. The level of benefits and coverage rules may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans

Medicare Advantage HMO
An MA HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Except in urgent or emergency care situations, medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by MA plan.

Medicare Advantage POS
An MA POS program is an option available through some Medicare HMO programs. It allows members to determine (at the point of service) whether they want to receive certain designated services within the HMO system, or seek these services outside the HMO’s provider network (usually at greater cost to the member). The MA POS plan may specify which services will be available outside of the HMO’s provider network.

Medicare Advantage PPO
An MA PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. MA PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PFFS
An MA PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan’s terms and conditions of participation. Acceptance is deemed to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The MA organization, rather than the Medicare program, pays physicians and providers on a fee-for-service basis for services rendered to these members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instances, where the provider is a network provider and the plan expressly allows for balance billing.

MA PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with BCBSVT.
- If you do provide services, you will do so under the Terms and Conditions of that member’s Blue Plan.
- Please refer to the back of the member’s ID card for information on accessing the Plan’s Terms and Conditions. You may choose to render services to an MA PFFS member on an episode of care (claim-by-claim) basis.
- MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan. We advise that you review them before servicing MA PFFS members.

**Medicare Advantage Medical Savings Account (MSA)**

MA Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

**How to Recognize Medicare Advantage Members**

Members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card.

*Eligibility Verification:*

- Verify eligibility by contacting (800) 676-BLUE (2583) and inputting an alpha prefix, or by submitting an electronic inquiry through the BCBSVT real-time eligibility search at www.bcbsvt.com.
- Be sure to ask if MA benefits apply.
- If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSVT.

*Medicare Advantage Claims Submission:*

Claims for non-Vermont Medicare Advantage or Vermont Blue Advantage members with a date of service January 1, 2021 or after
Claims for non-Vermont Medicare Advantage members with a date of service prior to January 1, 2021

- Paper Claim – BCBSVT, P O Box 186, Montpelier, VT 05601
- Electronic – submit to BCBSVT

Do not bill Medicare directly for any services rendered to an MA member.

Payment will be made directly by VBA.

**Medicare Advantage Claim Inquiries:**

- Must be done by email at MedicareAdvantage@bcbsvt.com, phone calls are not accepted.

**Traditional Medicare-Related Claims**

When Medicare is primary payer, submit claims to your local Medicare intermediary. The following are guidelines for the processing of Medicare-related claims:

- After you receive the Remittance Advice (RA) from Medicare, review the indicators:
  - If the indicator on the RA (claim status code 19) shows that the claim was crossed-over, Medicare has submitted the claim to the appropriate Blue Plan and the claim is in progress. You can make claim status inquiries for supplemental claims through BCBSVT.
    - You must wait 30 days from Medicare cross over date before submitting to BCBSVT.
  - If the claim was not crossed over (the indicator on the RA will not show claim status code 19 and may show claim status code 1), submit the claim to BCBSVT along with the Medicare remittance advice. You can make claim status inquiries for supplemental claims through BCBSVT.
- If you have any questions regarding the crossover indicator, please contact the Medicare intermediary.
- Do not submit Medicare-related claims to BCBSVT before receiving an RA from the Medicare intermediary.
- If you use Other Carrier Name and Address (OCNA) number on a Medicare claim, ensure it is correct for the member’s Blue Plan. Do not automatically use the OCNA number for BCBSVT.
- Do not send duplicate claims.
  - First, check a claim’s status by contacting BCBSVT by phone (800) 395-3389 or through an online claim inquiry at bcbsvt.com/provider.
Providers in a Border County or Having Multiple Contracts

We have three guides (Vermont and New Hampshire, Vermont and Massachusetts, and Vermont and New York) to assist you with knowing where to submit claims in these circumstances. These guides are located on our provider website at bcbsvt.com/provider/reference-guides.

International Claims

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You must submit the claim directly to BCBSVT.

Medical Records

There are times when the member’s Blue Plan will require medical records to review the claim. These requests will come from BCBSVT. Please forward all requested medical records with the request letter (it contains bar coding that assists in routing the medical records) to BCBSVT and we will coordinate with the member’s Blue Plan. Please direct any questions or inquiries regarding medical records to Customer Service at (800) 395-3389. Please do not proactively send medical records with the claim unless requested to do so. Unsolicited claim attachments may cause claim payment delays.

If you are including other documents with the medical records such as provider vouchers, other carriers’ explanations of payments, etc., make sure the document only contains the information related to the specific patient. If other members’ information is contained on the document and cannot be removed, please make sure to black it out.

Adjustments/Corrected Claims

Adjustments and Corrected claims are processed by BCBSVT for BlueCard® claims*. They must be filed within 180 days for the date of the original BCBSVT processing unless stated otherwise in provider contract.

*Medicare adjusted claims must be submitted directly to the member’s Blue Plan.

An adjusted/corrected claim is one which:

- Processed through to a provider voucher. If you are adding information, correcting information, or following the original provider voucher instructions, a corrected claim needs to be submitted. This can be done on paper or through an electronic transaction or

Note: If you are changing a member’s identification number and/or alpha prefix, do not submit as an adjusted/corrected claim. It must be submitted as a new claim.
Complete details on how to submit adjusted/corrected claims are located:

- Electronic Claims: on our provider website at www.bcbsvt.com under Electronic Data Interchange/837 (professional or institutional) Companion Guide.

**Adjustment reporting to a Provider Voucher**

- If the adjustment results in a decrease in payment, the claim will report as an “Account Receivable Created or Account Receivable Established” on the provider voucher.
  - The next issued provider voucher will report the adjustment as “Account Receivable Applied” and recover the amount due
- If the adjustment results in an increase in payment the recovery and repayment will not be held and report to the provider voucher.

**Returned Claim(s) Resubmission**

Most claims with errors or missing information will be sent to the provider through reporting to the provider voucher, however, there will be instances when we will still need to advise of claim error(s) that cannot be processed through to a provider voucher.

A form letter providing the specifics of the issue with the claim will be sent through the U.S. Postal Service. A copy of the claim will not be provided. You will need to update the claim accordingly and submit as a new claim (either a paper claim or an electronic claim). If submitting on paper, never mark the resubmitted claim with any type of message as this will only result in a delay in processing.

**Appeals**

Appeals for all BlueCard® claims are handled through BCBSVT. We will coordinate the appeal process with the member’s Blue Plan. There is a specific form for BlueCard® appeals on our website that must be completed and sent with all BlueCard® appeals.

**Coordination of Benefits Claims**

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member’s contract language explains how to determine which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If the member is covered by more than one health plan, and:

- BCBSVT or any other Blue Plan is the primary payer:
  - Submit the other carrier’s name and address with the claim to BCBSVT.
- If you do not include the COB information with the claim, the member’s Blue Plan may need to investigate the claim. This may delay the processing or result in non-payment of the claim.

- Other non-Blue health plan is primary and BCBSVT or any other Blue Plan is secondary:
  - Submit the claim to BCBSVT only after receiving payment from the primary payer.
  - Include the explanation of payment from the primary carrier.

- If you do not include the COB information with the claim, the member’s Blue Plan may need to investigate the claim. This may delay the processing or result in non-payment of the claim.

**Calls from Members and Others with Claim Questions**

If members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member’s Plan should not contact you directly regarding claims issues, but if the member’s Plan contacts you and asks you to submit the claim to them, refer them to BCBSVT.
Section 8

The Blueprint Program

NOTE: This section of the Provider Handbook is currently under development. A notice will be posted to the provider website when the updated version of this section is available. In the meantime, if you have any questions, please contact your provider relations consultant.
Section 9

The Federal Employee Program (FEP)

Introduction to FEP

FEP is a health-care plan for government employees, retirees, and their dependents. As a contracted provider/facility with BCBSVT, you must render services to FEP members who travel or live in Vermont. BCBSVT processes claims for FEP services rendered by Vermont providers in Vermont to FEP members.

This section is designed to describe the advantages of the program, while providing you with information to make filing claims easy. It offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

Advantages to Providers

FEP allows you to conveniently submit claims for members that receive services in the State of Vermont, regardless of their residence. BCBSVT is your point of contact for questions on services rendered in Vermont, including eligibility, benefits, pre-certification, prior approval and claim status.

Member ID Cards

When an FEP member arrives at your office or facility, be sure to ask them for a current membership identification card. The main identifier for an FEP member is the alpha prefix “R.” A correct member ID number includes the alpha prefix R followed by 8 digits.

The ID cards may also have:

- The abbreviation “PPO” inside a United States logo (PPO members only).
- The word “Basic” inside a United State logo

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for their current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient’s file.
- Member ID’s only generate in the subscriber’s name.
- The back of the ID card will have the member's local plan information; however, if you are rendering the services in Vermont, BCBSVT will be your point of contact.
• Make copies of the front and back of the member’s ID card so you can pass this key information on to your billing staff.

Remember: Member ID numbers must be reported exactly as shown on the ID card; they should never be changed or altered. Do not add or omit any characters from the member’s ID numbers.

Sample ID Card:

*Enrollment Code Key:

<table>
<thead>
<tr>
<th>Plan Option</th>
<th>FEHB Enrollment Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self</td>
</tr>
<tr>
<td>Standard Option (PPO)</td>
<td>104</td>
</tr>
<tr>
<td>Basic Option</td>
<td>111</td>
</tr>
<tr>
<td>FEP Blue Focus</td>
<td>131</td>
</tr>
</tbody>
</table>

Coverage and Eligibility Verification

Verifying eligibility and confirming the requirements of the member’s policy before you provide services is essential to ensure complete, accurate and timely claims processing. There are two methods of verification available:

• **Electronic:** Submit an electronic transaction via the tool located on the provider website at www.bcbsvt.com. Quick reference guides on how to submit transactions are posted to the eligibility link on the secure provider website.

• **Phone:** Call the Federal Employee Program customer service at (800) 328-0365.

Advanced Benefit Determinations

FEP members are entitled to BCBSVT reviewing and responding to “advanced benefit determinations.” This allows members and providers to submit a request in writing asking for benefit availability for specific services and receive a written response on coverage. For more information, see the FEP Section later in this Provider Handbook.
Prior Approval

FEP members require prior approval for certain services, with eligibility based on medical necessity. A complete listing of services is posted to the provider website at bcbsvt.com/provider, under the Prior Approval/Pre-Notification/Pre-Service Requests link. The lists of services is updated annually in January of every year. Please note: there are two separate prior approval lists for FEP members; one for members with a Basic and Standard option policies and one for members with a FEP Blue Focus policy.

Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/preauthorization for specific required services. When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

To obtain approval, call the Federal Employee Program at (800) 328-0365 and ask to be transferred to the utilization review area, or contact the utilization review area directly at (800) 922-8778.

The BCBSVT plan may contact you directly for clinical information and medical records prior to treatment, or for concurrent review or disease management for a specific member.

Claim Filings

Below is a description of how claims flow through the Federal Employee Program.

1. Member of Federal Employee Program receives services from you.
2. Provider submits claim to the local Blue Plan (if service was rendered in Vermont, submit to BCBSVT).
3. BCBSVT recognizes FEP member and processes the claim according to member's benefit plan
4. BCBSVT issues a Summary of Health Plan Payments to the member and a Provider Voucher to you.
5. You bill the member their reported liabilities from the Provider Voucher.

These helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including R alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at www.bcbsvt.com or by calling (800) 328-0365. Be sure to provider the member’s R alpha prefix.
- Submit all claims to BCBSVT, P.O. Box 186, Montpelier, VT 05601. Be sure to use the member’s complete identification number when you submit the claim, including the R alpha prefix (note
the R must be a capital letter). Claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.

- In cases where there is more than one payer and Blue Cross and/or Blue Shield Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue claim.
- Do not send duplicate claims. Sending another claim (or having your billing agency resubmit claims automatically) actually slows down the claims payment process and creates confusion for the member.
- Check claims status by contacting the Federal Employee Program at (800) 328-0365.

**Dental Services**

FEP members with a Basic or Standard Option policies have medical benefit coverage that provides benefits for select procedures that are identified under the Schedule of Dental Allowance and Maximum Allowance Charges (MAC). MAC are updated as of January 1st of every year. To obtain a current copy, please contact your provider relations consultant.

Note: FEP Blue Focus members do not have dental services available through their medical benefits.

**FEP BlueDental:** Members have the opportunity to purchase a dental supplement, FEP BlueDental. Members who have opted to purchase FEP BlueDental will have a separate identification card. It is important to request the member supply both ID cards (FEP BCBSVT and FEP BlueDental) at the time of the visit. Be sure to make copies of both cards to keep on file.

The FEP medical dental network consists of providers who have contracted directly with BCBSVT. The contract you hold with BCBSVT does not include the FEP BlueDental network.

The FEP BlueDental network (for Vermont) consists of providers who have contracted through CBA Blue. The Blue Cross and Blue Shield of Vermont (BCBSVT) FEP contract you hold does not make you eligible to receive benefits or be a network provider for the FEP BlueDental network.

Claims should be submitted first to the FEP program associated with the member’s medical benefit coverage for consideration of benefits. For example, if you rendered the services in Vermont, you submit to BCBSVT. If you rendered services in New Hampshire, you submit to Anthem BCBS. Once the claims have processed through the medical benefits coverage portion (you will receive your normal voucher), the claim will be forwarded to the FEP BlueDental network (if appropriate) for processing. You will receive the results of that processing directly from FEP BlueDental.

**When a FEP member does not have Medicare B**

In situations where a FEP member does not have Medicare Part B benefits, claims must be billed to BCBSVT following the Centers for Medicare and Medicaid Services (CMS) guidelines. Claim will be priced at the Medicare allowances for the services.
Section 10

Provider Voucher and 835 Transactions

Electronic Remits – 835 Transactions

Receiving claims data electronically has advantages:

- Reduced paper
- Reduced receipt time

We encourage providers to receive their provider vouchers electronically. Electronic Data Interchange/835 Companion Guides* are available at www.bcbsvt.com/provider/provider/electronic-business. If you have questions about electronic transaction requirements, please call Electronic Data Interchange (EDI) support at (800) 334-3441, option 2, or email us at editechsupport@bcbsvt.com.

*Updated Companion Guides are posted to the provider website at www.bcbsvt.com/provider/electronic-business.

**General Electronic Data Interchange Remit Information:** We provide electronic remits in an 835 HPAA-compliant format. The 835’s are available to provider/facilities for pick up or some providers choose to use vendors/clearing houses to receive and translate their 835’s. For a list of clearing houses, see www.bcbsvt.com/provider/provider/electronic-business.

**HIPAA compliant 835 Electronic Remittance Advice (ERA)**

835 files are placed on the BCBSVT secure SFTP site for pick up by the provider/vendor or clearinghouse. Details regarding the 835 files are located in the 835 Companion Guide available on our provider website at bcbsvt.com/provider/provider/electronic-business.

**Other Blue Plan 835’s**
In addition to the BCBSVT 835 we also post an 835 containing claim processing for their members who have a Medicare supplemental policy or a Blue Cross and Blue Shield policy secondary to Medicare that have crossed over from the Medicare COBA program.

The payments for the claims (if applicable, in the 835 reporting) will continue to be sent to you from the other Blue Plan in the method you are used to receiving; if historically, the other Blue Plan issued a check and provider voucher, that will continue in addition to the 835. If you usually receive an electronic fund transfer, that will continue.

Some information about the additional 835 file:

- Only claims crossed over to another Blue Plan by the Medicare COBA cross over program and are provider payable will be included in the 835
- You will only have an additional 835 on the weeks one is available for your practice/facility
- Payments (if applicable) are issued directly to you by another Blue Plan
- Member payable claims will not be included in the 835
- BCBSVT provider voucher will not be issued-you may receive one from the other Blue Plan with the payment (if applicable)
- The claims reported in the 835 are not on file with BCBSVT. Any questions related to the processing need to be directed to the customer service number on the back of the members identification card.

835 Reporting Variances:

Facility claims – if a DRG allowance exceeds the billed charges and there is a service line on the claim that is not eligible, the normal DRG calculation does not occur and therefore the negative amount is not reported.

Paper Provider Vouchers

A provider voucher is a document that reports back to practices/facilities information on how a claim(s) has been processed/denied/paid/adjusted and if balances are provider or member liabilities. All submitted claims process through a provider voucher. A list of frequently asked question provided at the end of this section.

Paper Provider Vouchers do not have to follow the HIPAA compliant Claim Adjustment Reason Code (CARC). This allows us to provide a more detailed explanation of how the claim processed or why it denied. If you are questioning a claim processing on the 835, it may benefit you to review the Provider Voucher for further explanation.

Overview of a provider voucher:

- There are three types of vouchers
  - Federal Employee Program
  - BCBSVT and BlueCard®
  - The Vermont Health Plan
- Generated on Tuesdays of every week. Holidays do not impact the weekly processing cycle.
- Mailed* by Friday through the U.S. Postal Service and will include a paper check if payment is due and provider is not set up for electronic payment.
*We do not mail paper vouchers to practices who receive electronic payments. They are expected to review/print/save from the Provider Resource Center.

- Posted to the Provider Resource Center in a PDF format. (All providers/facilities have access, but if you are an electronic payment provider, you must go to this location to review/print/download the voucher).
- Electronic payments are deposit on Friday*, for those providers who receive electronic payments.
  *If Friday is a federal banking holiday, funds are deposited on the following Monday.

Format of a Provider Voucher (sample on pages to follow):
- Uniform format and reporting for professional (CMS 1500 billers) or facility/ancillary (UB 04 billers) is the same.
- Each voucher contains up to 400 transactions.
  - Practices/facilities having more than 400 transactions will have multiple vouchers.
- The information reports to the voucher in the following order:
  - Rendering provider National Provider Identifier (NPI) - professional provider voucher only
  - Payment Category (example: paid claims, non-paid claims, adjustments, etc.)
  - Patient Name (last, first)
  - Patient Account Number (if multiple claims, then in account number order)
  - Claim Number
  - Line Number (except facility—they report at the claim level*)
- Facility/ancillary (UB 04 billers) both inpatient and outpatient services will report at the claim level*. Note: Details on all lines and processing are contained in the 835 or by reviewing the claim on our secure provider portal.
- Professional (CMS 1500 billers) will report at the claim detail level**.
  * Claim level is defined as the total charges of a claim.
  **Claim Detail level is defined as each claim line.

Information Contained on the Provider Voucher:
- Claim specific processing
  - Reporting of standard allowance
  - Reporting of member liability
  - Reporting of contractual reductions
  - Explanation codes of how the claims processed.
    - Some of the explanation codes have BCBSVT specific messaging with more detail than the HIPAA claim adjustment reason codes and remarks that report to an 835 transaction.
- Denied claims
  - May require action from the provider/facility in order for processing to continue or be considered. Must be resubmitted as a corrected claim.
- Adjustment reporting to a Provider Voucher
If the adjustment results in a decrease in payment, the claim will report as an “Account Receivable Created or Account Receivable Established” on the provider voucher. This is informational that the next provider voucher that has enough money to cover the adjustment will be taken that

The next issued provider voucher that has enough money to cover the adjustment, will report the adjustment as “Account Receivable Applied” and recover the amount due

If the adjustment results in an increase in payment the recovery and repayment will not be held and report to the provider voucher.

Adjustment(s) resulting in no change in processing:

- Some of the adjustments may result in no change in processing. These adjustments report to the provider vouchers as informational. There is no retraction of the original claim or repayment, just a restatement of the original claim processing with the following message:

  “THE ABOVE ACTION REFLECTS AN ADJUSTMENT OF $XXXXX TO OUR ORIGINAL PAYMENT. PLEASE NOTE THAT THIS ADJUSTMENT RESULTED IN NO ADDITIONAL PAYMENT. HOWEVER, PLEASE REFER TO THE PATIENT COLUMN TO DETERMINE IF THERE IS A CHANGE IN THE PATIENT’S LIABILITY / 2083”.

  Note: BCBSVT-initiated adjustments without any change in processing, do not report to 835’s.

See below for a sample voucher:
### PROVIDER VOUCHER

<table>
<thead>
<tr>
<th>SERVICE CODE</th>
<th>PROCEDURE CODE</th>
<th>TOTAL CHARGES</th>
<th>ALLOWED AMOUNT</th>
<th>OTHER INSURANCE DOLLARS</th>
<th>PROVIDER'S LIABILITY</th>
<th>SUBSCRIBER'S LIABILITY</th>
<th>APPROVED TO PAY</th>
<th>AMOUNT PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUB ID:</td>
<td>CLAIM:</td>
<td>$5,500.00</td>
<td>$4,400.00</td>
<td>$0.00</td>
<td>$1,100.00</td>
<td>$0.00</td>
<td>$4,400.00</td>
<td>$5,194.25</td>
</tr>
<tr>
<td>11/29/16</td>
<td>006/000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A-Your payment includes an interest payment of 97% of (2010)

SUBTOTALS:  
006/000

TOTAL:  
$5,750.00  
$4,650.00  
$0.00  
$1,100.00  
$30.00  
$4,620.00  
$5,453.96
Explanation/Information on Fields of the Provider Voucher

Note: We are only providing details and information in those fields that may not be intuitive.

Reference Number: Paper check number or if you receive electronic payment; your transaction number.

Payment Date/Electronic Payment date: The date will reflect the date the voucher was created. If an Electronic Payment deposit box appears as well, this means you receive electronic payments and it will be the date the transaction will be deposited to your bank account.

Column Headers:

- **Procedure Code:** Reports the CPT, HCPCS, NDC, or DRG.
  - Non-DRG facility claims (UB 04) do not report any information in this field, as they are reported at the claim level.
  - Modifiers, if submitted, do not report back through the provider voucher.
  - Revenue codes do not report to the provider voucher.
  - Professional claims (CMS 1500 biller) will report a place of service code in addition to the CPT, HCPCS, NDC, DRG code billed. This code is an internal code and will not align with the CMS place of service code. You can disregard this information and be assured we have processed based on the CMS place of service reported on your claim.

- **CVD/NCVD:** This stands for covered (CVD) or non-covered (NCVD). BCBSVT is not utilizing this field, only the header will appear.

- **Provider’s Liability:** This reports the amount that a provider is contractually required to write off.

- **Subscriber’s Liability:** This field combines and reports all of the member’s liability for the services provided, which may include deductible, copayment, co-insurance, etc.

- **Approved to Pay:** The actual amount of money the claim has paid.

- **Amount Paid:** The actual amount of money the claim paid, plus any interest.*

- **RSN Code:** A code will be reported to reflect the processing of the claim. The written explanation of that code reports after the claim information.

*Interest payment dollars report in the explanation of processing area of the provider voucher.

**Sub ID:** The identification number of the patient the claim was processed for.

- BlueCard and FEP will report back the member’s alpha prefix.
- BCBSVT will report the member’s ID without a prefix.

**Patient Acct/Prescription #:** This field will report the patient account number reported to us from the claim. BCBSVT is not utilizing the Prescription# field, however column heading will appear.

Notes:

Patient account number reporting on the paper provider voucher has limitations:

- 15 characters for facility claims (UB 04)
- 12 characters for professional claims (CMS 1500)
If a reported patient account number exceeds the allowable characters, only the first eligible characters will be reported back on the paper provider voucher.

Special characters or spaces:
- Submitted through a 837 will not report through the provider voucher
- Submitted on a paper claim may not report back, it will depend on how the claim is entered into the BCBSVT system

**Provider Voucher Reporting Variances:**

FEP Dental Claims - If you bill a charge greater than the Maximum Allowable Charge (MAC), the provider voucher reports the allowed amount as the billed charge, instead of the MAC. Please disregard. The amount paid, and subscriber's liability accurately report and equal the MAC. The provider liability is the difference between the MAC and the billed charge and reports correctly under provider liability.

**Frequently Asked Questions about the Paper Provider Voucher**

**Q:** Why did my provider voucher deny a line of a claim for invalid/inaccurate data, but denied the rest of the lines for membership not in effect or not found?

**A:** Claims are reviewed for complete, accurate information before applying membership and benefits.
- Claim lines that are incomplete/inaccurate, deny and report a provider liability. Those lines must be corrected and submitted as a corrected claim to complete processing.
- Complete/accurate claim lines process through look at membership and benefits and deny as a member liability.

**Q:** The paper provider voucher (outpatient or inpatient services) reflects a member liability (deductible, co-payment, co-insurance), however there is coding (CO163/M127) and verbiage “Final benefit determination cannot be made until we receive specific requested medical records.” So which is it, it processed and applied to deductible, or pended for medical records?

**A:** The provider voucher “rolls” all services on a claim up to the claim line level, reporting all messages related to the processing of the claim. To fully understand the processing of the services and which message applies to what line, you have to either review the 835 or contact customer service at (800) 924-3494.

**Q:** Claims are being denied for lack of or incorrect information in the present on admission indicator.

**A:** The only valid POA indicators are Y, N, U, & W. One of these must be present on all claims, paper or electronic, unless exempt from the POA reporting as defined by Appendix I – Present on Admission Reporting Guidelines.

There are 36,000 ICD-10-CM codes exempt per the Appendix I – Present on Admission Reporting Guidelines from POA submission. For those dx only, no POA is to be reported. Paper claims are to report a 1 and electronic (5010 837I) need to report a blank field.
A list of the 36,000 exempt POA codes can be found in the “Rules” section of ICD10Data.com.

Q: BlueCard claims that have denied for lack of prior approval are reporting as a member liability?

A: The reporting as a member liability is correct. For BlueCard members, prior approval is the responsibility of the member and they are held financially responsible if it is required and not obtained.

There is one exception for Inpatient Services: facilities are financially responsible to obtain the prior approval/pre-certification/pre-notification if required by the member's home plan.

**General Information about 835’s and Paper Provider Vouchers:**

- Issued on Tuesdays
- Paper Provider Vouchers are posted to the Provider Resource Center by Wednesday
- 835’s available for pick up on Wednesdays

*ClaimsXten-Select™ Software - Addition of Lines*

See section 6.4 for details on the ClaimsXten-Select™ software.

**Code Replacement**

If the logic finds a different code should have been billed, a line will be added. Paper vouchers will report an explanation of processing at “The claim line was added due to a payment recommendation by CXT-S”.

**Unit Limit Exceeded**

If a claim is received with multiple units of service that exceeds the amount allowed, the paper provider voucher will reflect the denied claim line, an added line for the acceptable number of units and a denied line for the remaining units to balance. For example if a claim is received for 2 units and we only allow 1, we will deny the claim line with the 2 units and add a pay line for the 1 unit and a denied claim line for 1 unit. The 835 will reflect only the denied line for 2 units and the paid line for 1 unit.