Blue Cross VT PROVIDER HANDBOOK

2026

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Please Note: This provider handbook is not applicable to CBA Blue or Vermont Blue Advantage.

For CBA blue, please visit: www.cabluevt.com/provider-resources/

For Vermont Blue Advantage, please visit: www.vermontblueadvantage.com/providers (note: VBA is not selling products in 2026)

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Introduction

This handbook is designed to provide the details regarding Blue Cross and Blue Shield of Vermont (Blue Cross VT)—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 within may change.

Notices related to changes in the handbook are communicated through our monthly eNewsletter. Changes from previous version of the Provider Handbook are highlighted in red font.

Section 1

General Information on Blue Cross VT

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 Blue Cross VT 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 Blue Cross VT and TVHP

A customer service team specializing in provider issues is available to you by email or phone. To ensure your inquiry is directed to the correct department, please see the grid located at www.bluecrossvt.org/providers under Provider Forms and Resources, Additional Resources, Contact Information for Providers.

We generally respond to email within three business days. 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)

*Email is recommended as our phone hold times may be long. When emailing, please include the billing NPI number, member name, member identification number, member date of birth and date(s) of service to reduce the overall response time. Please note, all emails sent by Blue Cross VT are secure and HIPAA compliant.

CustomerService@bcbsvt.com for Blue Cross VT, New England Health Plan, Access Blue

FEPCustomerService@bcbsvt.com for Federal Employee Program

Bluecard@bcbsvt.com for BlueCard

NOTE: Medicare Advantage claims including those for Vermont Blue Advantage members are handled by Vermont Blue Advantage provider services team by phone at (844) 839-5122. Do not contact Blue Cross VT.

Office Training and Orientation

Your provider relations consultant can assist you in several ways:

- Provider contracting information and interpretation
- Onsite visits
- Provider and office staff education and training
- Information regarding Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT/TVHP email.

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

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

Member Rights and Responsibilities

Click here for details: bluecrossvt.org/members/member-rights-responsibilities

Privacy Practices of Blue Cross VT

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 bluecrossvt.org/privacy-policy . To request a copy by mail or email, contact the provider relations team.

Section 1.1

Health Insurance Portability and Accountability Act (HIPAA) Responsibilities

Blue Cross VT, 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). Blue Cross VT, 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 Blue Cross VT 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 Blue Cross VT 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. Blue Cross VT/TVHP shall not be liable for payment remitted to Provider's Business Associate prior to receipt of such notification. Notifications should be sent to:

Blue Cross and Blue Shield of Vermont
Attn: Privacy Officer

PO Box 186
Montpelier, VT 05601-0186

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

Standard Transactions: The provider and Blue Cross VT/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

Blue Cross VT/TVHP Contracts

Contracting with Blue Cross VT

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

Contracts are effective upon signature of all parties (or Providers' satisfaction of credentialing requirements, whichever is later)

In general, Blue Cross VT 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 Blue Cross VT cannot directly contract with a provider physically located outside the state of Vermont (or a contiguous county) who is providing services via telemedicine or telephone (audio) only.

Blue Cross VT contracted providers **temporarily** located outside of the State of Vermont but within the United States for a period not to exceed six months are allowed to continue to contract with Blue Cross VT and provide eligible services by telemedicine, submitting claims to Blue Cross VT for processing.

If at any point the relocation becomes permanent or the six-month time period is exceeded, the Blue Cross VT contract is terminated, and claims for services can no longer be submitted to Blue Cross VT. Claims must be submitted to the Blue Plan where the provider is physically located when the services are rendered.

Out of Country services are not allowed under any circumstance.

Notes:

- There are allowances if a provider is affiliated and billing through a Blue Cross VT contracted practice physically located in the State of Vermont or a county contiguous to Vermont.
- Out of Country relocation, even if temporary, will terminate your Blue Cross VT contract.

If you have a specialty that is recognized by CMS, you must be enrolled with Medicare or you need to opt out of Medicare. If you choose to participate with Medicare, your contract will include participation in our Medicare Advantage product (Vermont Blue Advantage). If you opt out of Medicare, your contract will exclude Medicare Advantage.

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 (if you participate with CMS)
- 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 processing information (and if applicable, payment) from us.

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 Blue Cross VT offers the following advantages:

- Direct payment (Electronic Fund Transfer) for all covered services (excluding any reported member liabilities) offers safe, free of charge, improved cash flow and eliminates having to wait for paper checks. https://www.bluecrossvt.org/providers/provider-electronic-payment All Blue Cross VT contracted practices, based on tax identification number must sign up.
- Claims are processed in a timely manner. We make available either electronic (835) or provider vouchers posted to our Provider Resource Center which detail payments, patient responsibilities, adjustments, and/or denials.
- 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 Blue Cross VT 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, and provider contracts.
- Our 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 emails, eNewsletters, 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, member eligibility, provider vouchers, prior authorization submission/status, etc.

Contracts are extended at the time a new enrollment is received as applicable.

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 details.
- Independent Clinical Laboratories need to contract with our Laboratory Benefit Manager, Avalon. To initiate the contracting process, please contact Avalon via email at Avalon-providers@avalonhcs.com.
- Providers or practices that offer only telemedicine or virtual care need to provide additional information prior to enrolling.

Termination of Contract

Our "Provider Contract Termination Policy" is located on the provider website under Provider Policies, Provider Appeals and Contract Policies.

Contracted Provider Objection to New or Modified Policies and Manual Changes

In accordance with 18 V.S.A. § 9418c contracted providers have the right to object to new or modified policies and manuals changes.

Providers who object must do so within 60 days of the date of notice related to a policy or manual change. The rationale for the objection to the change must be in writing including related areas of the policy or manual and rationale or reasoning for the objection.

These objections must be directed to Provider Contracting. This can be done by email at: providercontracting@bcbsvt.com or US Postal Service BCBSVT Attn: Provider Contracting, PO Box 186, Montpelier, VT 05601.

Within 5 business days of receipt, the sender will receive confirmation of receipt of the objection.

Section 1.3

Definition of Network Provider

We define primary care provider and specialty care provider as:

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 website under Provider Policies, Quality Improvement Policies.

Specialty Care Provider (SPC):

Any 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 (PCPs) and specialty care providers (SPCs) must meet. These requirements are defined in our contracts, this provider handbook and our policies. Policies are located on the provider website under Provider Policies, Vermont Medical Policies.

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 ensure 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.
- **Work with Patients to Reduce Chances of an Unplanned Hospital Readmission**
    - **Post Discharge**
        - Follow-up Appointments—Keep appointments open so your office can see patients within 7 days.
        - Medication Management—Ask your patients to bring all medications they were taking pre-hospitalization and any new ones they are supposed to be taking after discharge (including over-the-counter pills, liquids, topicals, vitamins and supplements).

- Discharge Summary—Obtain the discharge summary (or ask the patient to bring a copy) to help with continuity of care.

- **During the Visit**
  - Medications—reconcile medications and ask the patient and/or caregiver to describe the new medication regimen back to you. Document their understanding of the medication plan.
  - Lab/Tests—Address all follow-up tests and lab results ordered prior to discharge, and provide appropriate interventions as needed.
- **Next Steps**
  - Confirm the "**W**s"—The patient should know with **w**hom, **w**hen, **w**hy and **w**hat happens next for any upcoming appointments.
  - Visit Summary—Provide a copy of the visit summary to the patient to review later. Include new medications, test results, future appointments with specialists and any scheduled tests.

Please refer to our Inpatient Hospital Readmission Payment Policy CPP_21 for details of readmission services that are not eligible for additional reimbursement.

Use of Non-Network Providers: Our Payment Policy CPP_20 for the "Use of Non-Network Providers," is located on our provider website under Provider Policies. This policy articulates our expectations regarding the use of non-network providers and details how Blue Cross VT enforces the requirements outlined in providers' contracts.

Confidentiality and Accuracy of Member Records: For details, refer to the "Site Visit and Medical Record Keeping" policy on the provider website under Provider Policies, Quality Improvement Policies.

Access to Facilities and Maintenance of Records for Audits: Refer to the "Provider Audit, Sampling and Extrapolation, and the Re-Audit Process - CPP_19" policy on the provider website under Provider Policies, Provider Payment Policies.

Maintaining accurate Directory Information: For details in Section 1.8 below.

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

Note: See Section 12 for details on Act 111 – Primary Care Provider of Prior Authorization for details on providers, members and services that qualify for a waiver of prior approval.

Details, including lists of services and related forms are available on our provider website under Authorization.

- **Advanced Benefit Determinations:** Federal Employee Program (FEP) members are entitled to a Blue Cross VT 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 or approval of continued stay 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 medical notes must be included.
    - 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 request a review through customer service within the designated timely filing period rather than submitting an appeal.
- **Mental Health Substance Use Disorder:** MH/SA stays have different allowances.
- **Prior Approval:**
  - Participating and network providers are financially responsible for securing prior approvals before services are rendered, even if a Blue Cross VT policy is secondary to Medicare. There are some exceptions for Medicare Primary; please refer to the prior approval list for details.
  - Participating and network providers can be held financially liable for the use of non-network providers.
  - Act 111 Primary Care Provider of Prior Authorization, please refer to Section 12.

  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

Please see Section 11 for information specific to DME suppliers

After-Hours Phone Coverage

For details, refer to the policy "Accessibility of Service and Provider Administrative Services," which is available on our provider website under Provider Policies, Quality Improvement Policies.

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. We place calls 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 "Accessibility of Services and Provider Administrative Service Standards" on the provider website under Provider Policies, Quality Improvement Policies. This policy provides details on the definition, policy, and methodology for analyzing practitioner performance and reporting.

Reporting of Fraudulent Activity

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

- Blue Cross VT 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.

Blue Cross VT Audit

The complete "Provider Audit, Sampling and Extrapolation, and Re-Audit Process" policy CPP_19 is available on our provider website under Provider Policies, Provider Payment Policies.

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 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 Blue Cross VT Quality Improvement Policy, "Availability of Network Practitioners Analysis Policy" 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 us, accept our payment rates, and adhere to our credentialing and performance requirements. A request for a specialist to act as their 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 member in the second or third trimester of pregnancy may continue with their 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 their occupation;
- control their 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 their 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 their 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 of 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 practice the PCP left if the practice has the capacity to take on the patients, or (2) move the members to a different PCP/practice that is open to new patients and able to take the members on.

*Provider must be enrolled, credentialed, and have a contract (or be part of a vendor/group contract) approved by Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT: members would remain at ABC practice or be moved to another PCP practice with an open panel that 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 Blue Cross VT): members would remain at ABC practice or be moved to another PCP practice with an open panel that can take on the patients.

Provider-Initiated Member Transfer

A PCP may request to remove a member from their 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 their 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 consultant's contact information, the request may 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 bluecrossvt.org 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 under Provider Forms & Resources, Additional Resources.
- **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 bluecrossvt.org/member.

Section 1.5

Enrollment of Providers

Enrollment and Credentialing Requirements

To enroll, the group or individual must hold a contract with Blue Cross VT/ TVHP.

Provider groups must (1) enroll **and** (2) credential individual providers who are associated with the group. The provider must enroll under the group to be part of the group's contact and be eligible to bill. This is done by the submission of a Provider Enrollment Change Form with required documentation. Please see the Enrollment and Credentialing area of our website at www.bluecrossvt.org/providers/enrollment-and-credentialing.

Effective dates of change are defined in provider contracts.

Notes:

- Providers joining existing, contracted groups with Blue Cross VT are **not** eligible to render services to any Blue Cross and Blue Shield member (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage) until they are fully (1) enrolled under the group and (2) approved by the credentialing committee. Credentialing is required if the provider does not have an approved, active credential status with Blue Cross VT.
    - Note: Locum Tenens must complete a provisional credentialing process before they are eligible to render services to any Blue Cross VT/TVHP (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage) members.
- Providers enrolling with Blue Cross VT need to make sure their National Plan and Provider Enumeration System (NPPES) file is up to date—practice location(s), taxonomy, phone number, etc. NPPES is located at: https://nppes.cms.hhs.gov/#/. Blue Cross VT and our partners use NPPES to validate provider information.
- Providers/Practices who offer only telemedicine or virtual care must contact the Provider Contracting department at providercontracting@bcbsvt.com before completing any enrollment information.

Enrolling a New Group or Provider (including Locum Tenens)

Details on the requirements for the enrollment process with Blue Cross VT can be found on our provider website under Enrollment and Credentialing.

Submission of enrollment is done through our online enrollment tool.

In addition to enrollment, providers not already credentialed by Blue Cross VT will need to go through a credentialing process. See Section 1.6 below.

Use of Third-Party Enrollment or Credentialing Vendors

We define third-party enrollment or credentialing 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 enrollment and/or documentation on a practices/provider's behalf.

We do not provide any customized reporting to these vendors. Provider/Practices need to work with their vendors to provide the details the vendor may need to oversee the enrollment and credentialing.

If needed, a provider/practice can request a demographic report from the provider relations team (providerrelations@bcbsvt.com) that the practice can forward on to the vendor. A demographic report contains basic information about who is affiliated to a practice, the locations of providers, phone numbers and patient panel status – it is similar to the quarterly CAA validation practices receive.

Enrollment Durable Medical Equipment (DME)—Additional documentation

In addition to the standard documentation required for enrollment of a group, DME suppliers are required to supply proof of accreditation by one of the following:

- o Accreditation Commission for Health Care (ACHC)
- o Community Health Accreditation Program (CHAP)
- o The Compliance Team Inc. of Exemplary Providers (TCT)
- o Healthcare Quality Association on Accreditation (HQAA)
- o The Joint Commission (TJC)
- o The Board for Orthotist/Prosthetist Certification (BOC)
- o American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCs)

If you have various locations with separate licenses or accreditations, you must submit copies of the licenses or accreditation information for each location covered by your contract with Blue Cross VT.

Enrollment Home Infusion Therapy (HIT)—Additional Documentation

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

- Proof of accreditation by one of the following:
  - 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

If you have various locations with separate licenses or accreditations, you must submit copies of the licenses or accreditation information for each location covered by your contract with Blue Cross VT.

Enrollment of 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

Follow the instructions in "Enrolling a New Group or Provider (including Locum Tenens)" earlier in this section. In the comment field on the Provider Enrollment and Change Form (PECF), note "MTM Pharmacist."

Section 1.6

Credentialing of Providers

We partner with Verisys, a national credentials verification organization (CVO), to perform the primary source verification function of credentialing. Blue Cross VT performs all other credentialing functions.

Our Quality Improvement Credentialing Policies: (1) "Facility Credentialing" (2) "Practitioner Credentialing" and/or (3) "Ancillary Provider Credentialing" define requirements, the process, credentialing and recredentialing criteria, and rights and responsibilities. The policies are located on our provider website under Provider Policies/Enrollment and Credentialing Policies

Provisional Credentialing – only applies to Locum Tenens

Locum tenens must complete a provisional credentialing process. Until the provisional credentialing process is complete and the locum tenen is approved, they are not eligible to render care to any Blue Cross and Blue Shield member (including CBA Blue, the Federal Employee Program and Vermont Blue Advantage). If they do and claims are submitted, the claims will deny as a provider liability.

Provisional credentialing can take up to 5 business days to complete, if all required information is submitted and current and there are no concerns with the provisional credentialing findings. If there are issues with the provisional credentialing findings, the time frame to complete the process will vary depending on outside factors.

Provisional credentialing cannot be approved retroactively. The locum tenen's effective date for inclusion in our networks will be as of the approval date of the provisional credentialing. You will receive a notice that advises when the provider is approved and effective to start to provide care to Blue Cross and Blue Shield members.

If the PECF form indicates the locum tenen will be active more than 60 days, in addition to the provisional credentialing, we will also start the full credentialing process so there will be no interruption of the locum tenens network status.

Initial Credentialing Process

Before credentialing with Blue Cross VT, you must complete or update your Council for Affordable Quality Health care (CAQH) application. There is an overview of this process below. Please refer to the "ProView Provider User Guide" on the CAQH website for details.

- 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 issues 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 Blue Cross VT as an authorized agent, allowing Blue Cross VT access to your credentialing information.
- If you encounter any difficulties uploading updated supporting information, documentation may be emailed to documents@proview.caqh.org.

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

    The registration forms 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 Blue Cross VT 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 may be emailed to documents@proview.caqh.org.

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. After completion of the profile, supporting documentation should be mailed to:

CAQH
P O Box 696537
San Antonio, TX 78269

You will need to request that Blue Cross VT be assigned as an authorized agent, allowing us access to your credentialing information. Alternately, you may request a "global authorization" that will allow all carriers access to your profile.

Once authorization has been given and your application is complete, CAQH will provide notification and Verisys 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.

Re-Credentialing of Providers

We re-credential providers at least every three years following their initial credentialing date.

Most providers will not even realize they are in the re-credentialing period if CAQH is up to date and attested to, the process is able to be done without any provider interaction.

However, if CAQH is not up to date or attested to you will receive a letter. Letters are sent from Verisys, through the US Postal Service to the provider's correspondence address on file at Blue Cross VT. It is important to respond to these requests promptly, or you could risk a break in credentialing (see below for details on what that means). All details of what is needed to re-credential and how to contact Verisys are detailed in the letter.

It is a provider's responsibility to ensure their CAQH profile is updated and reattested on a quarterly basis to ensure there is no delay in the re-credentialing process.

We may extend a provider's re-credentialing cycle time frame (beyond the 36 months) if the practitioner is:

- On active military assignment
- On medical leave (e.g., maternity leave)
- On sabbatical

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

Re-credentialing denial letters are sent within 60 days of the decision date.

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 must be initiated. This process can take up to 90 business days and during that time period, providers are not eligible to see Blue Cross and Blue Shield members. As of the date a provider is approved by the credential committee eligibility to see and bill for Blue Cross and Blue Shield members begins. Retroactivity in credentialing is not allowed.

Provider Going on Sabbatical

See section 1.7.

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" above for details on how your CAQH profile impacts your Blue Cross VT demographic information.

You must complete appropriate paperwork when you have a change in practice. Failure to keep your information up to date can impact members, claims, and your practice.

Reminder: Blueprint Patient-Centered Medical Homes (existing or new) need to inform Blue Cross VT 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
- 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 (NPI)

Provider Groups:

- Tax identification number (include updated IRS Form SS-4 notice (provides verification of EIN)
- Billing national provider identifier (NPI)
- Physical, mailing and/or correspondence address
- Group name

Details can be found on our provider website under Provider Forms & Resources, Group Practice or Independent Provider Demographic Change Forms.

***Please note**: CBA Blue does not use Blue Cross VT provider addresses. If you have a change in address, you will need to notify CBA Blue Provider Maintenance team at providermaintenance@cbabluevt.com.

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 period of time need to suspend their network status. Notification must be sent to providerfiles@bcbsvt.com and include the date when they are leaving and expected date of return. During the sabbatical period, the provider will not be marketed in any directories and will have members temporarily reassigned to another contracted Blue Cross VT contracted provider if a covering provider within their own practice is not identified.

If on sabbatical during a recredentialing cycle, we will extend the re-credentialing period.

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 /Change Form (PECF).

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 assigned patients.

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 Blue Cross VT/TVHP members.

Blue Cross VT notifies affected members of a provider termination 30 days in advance of the effective date of termination.

You can submit a Provider Enrollment/Change Form at bluecrossvt.org/provider.

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:

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

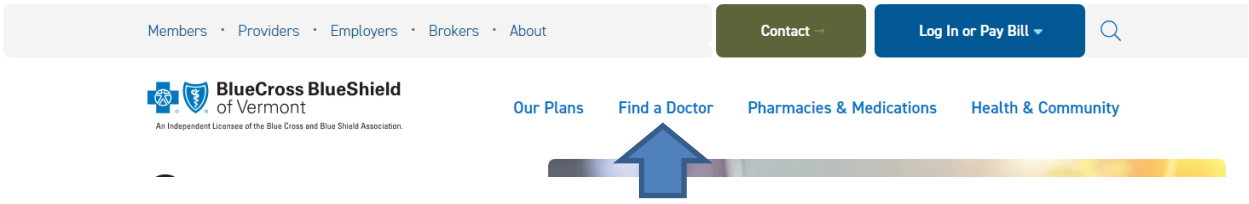
Section 1.8

Blue Cross VT Marketing of Providers in Member Directories

Online Provider Directory

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

Most* enrolled, contracted and credentialed providers are marketed in our online provider directories, located at bluecrossvt.org under the "Find a Doctor" tool.



*There are a few exceptions:

- Providers who practice exclusively within the facility or free-standing settings and who provide care for Blue Cross VT 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 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 these entities are accepted:
    - American Board of Medical Specialties: www.abms.org
    - American Midwifery Certification Board: amcbmidwife.org
    - American Nurses Association: www.ana.org
    - American Osteopathic Association: www.osteopathic.org
    - The Royal College of Pathologists: www.rcpath.org
    - The Royal College of Physicians: www.rcplondon.ac.uk
    - The College of Family Physicians of Canada: 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 services by telemedicine only, a physical address is not listed. Instead there is a note “call to schedule services.”

Practice Name as Listed in Online Provider Directory

The name reported on the IRS Form SS-4 notice (provides verification of EIN) is the name we display in our online provider directory.

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 online provider directories located at bluecrossvt.org, “Find a Doctor” tool. This tool provides our members (your patients) with important information about your providers. Please make sure it is accurate.

When reviewing the information in the online 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.
- 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 on our provider website under Enrollment and Credentialing.

Consolidated Appropriations Act (CAA) Directory Validations

See the Enrollment and Credentialing area of our website: https://www.bluecrossvt.org/providers/enrollment-and-credentialing under CAA Directory Validation for an overview of the process and instructions on how to complete the quarterly validations.

Providers are required to complete each quarter or risk removal from the Provider Directory, denial of claims (scheduled for second quarter of 2026) or possible termination of contract.

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 per member per month (PMPM). It varies according to factors such as the age and gender 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 around the 20th of each month. The report is posted to the Provider Resource Center (secure area for providers), under the Provider Voucher link.

   Additional information on capitation:

   - 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 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 Method

Enrollment into Electronic Fund Transfer (EFT) is required for all Blue Cross VT contracted practices based on tax identification number. EFT is safe, free of charge, improves cash flow and eliminates having to wait on paper checks.

Information on signing up for Electronic Payments can be found on our provider website under Provider Electronic Payment.

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 Blue Cross VT 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.

Electronic payments are issued by Wells Fargo Bank.

Claims are finalized and moved to the payment process on Tuesday of every week. Provider vouchers/835's are available on Wednesdays, and electronic payments are issued every Friday (holidays may impact the Friday EFT, if this occurs, advanced notice is provided).

Reimbursement Terms

Payments for Blue Cross VT are limited to the amount specified in the provider's contract with Blue Cross VT, 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

Blue Cross VT Provider Website and the Provider Resource Center (PRC)

The Blue Cross VT website located at bluecrossvt.org 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 (bluecrossvt.org/provider) and a secure area, the Provider Resource Center (PRC) that only registered users can access.

The general area of the provider website contains information such as provider news, forms, medical and payment policies, the Provider Handbook, and other tools and resources.

The PRC contains information such as member eligibility and benefits and claim status for Blue Cross VT, FEP, and BlueCard members.

To become a registered user, you will need to work with your local administrator (the 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, go to the Provider Resource Center and follow the instructions to register as a new user. Blue Cross VT does not allow for the sharing of usernames and passwords. Each user MUST have their own username and password.

Registration for our PRC can save you time. Callers to our customer service department who have a claim status question may be redirected to the PRC for self-service.

We have a Provider Resource Center Reference Guide available on our provider website under the link Provider Forms & Resources, Additional Resources. 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 should be directed to the Provider Relations team.

Section 3

Blue Cross VT 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 (UM) 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 integrated health staff is available to receive and place calls during normal business hours (8 a.m. to 4:30 p.m., Monday through Friday). The integrated health staff do not place outgoing calls after normal business hours. 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 via our Provider Resource Center (PRC) at any time. (The PRC allows for clinical information to be attached to 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 Blue Cross VT. 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 Care Guidelines (MCG), Inpatient and Surgical Care and Ambulatory, and Recovery Facility Guidelines
- Blue Cross and Blue Shield of Vermont medical policies
- Blue Cross and 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 procedures/services based on the need to direct care to specific providers, coverage issues, or quality concerns about the medical necessity for the requested procedure/service. 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:

- Some cosmetic procedures, e.g., breast reduction
- Organ transplants
- Out-of-network for point of service product(s) and managed products
- Experimental procedures/protocols

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 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 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 the provider contract.)

Our utilization management staff will not accept any financial incentive relating to utilization management 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 (800) 922-8778 (option 3) or (802) 371-3508 if they want to discuss a UM denial with our physician or pharmacist.

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 website under Policies, Quality Improvement Policies.

The clinical practice guidelines serve as resources that aim to standardize healthcare practices by adopting evidence-based guidelines which can help positively impact outcomes. The guidelines can assist practitioners, as well as members, in making informative decisions about appropriate health care for specific clinical situations.

Blue Cross VT adopted guidelines for clinical practices are located on the provider policies page: https://www.bluecrossvt.org/providers/provider-policies under the Clinical Practice Guidelines 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 and 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 and Blue Shield Association Medical Policy Manual provides an informational resource which, along with other information, a member Blue Cross and 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 ensure relevance with current practice. The committee considers input from practicing physicians, psychiatrists, and other health providers, including providers under contract with the Plan, if applicable. Upon request, the guidelines are available to all providers under contract with the Plan as well as members and their treating providers.

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

Advanced Benefit Determination

Federal Employee Program (FEP) members as a courtesy 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. Please clearly mark the form (preferably at the top) “Advanced Benefit Determinations.”

Advanced Benefit Determinations (ABD) should only be used for non-urgent services, procedures or medical equipment. Even if marked as urgent, they will follow the standard response timeframe.

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 under Prior Approval Authorization.

Prior Approval

Prior approval is required before services are rendered for coverage of out of network/non-participating providers*as well as some supplies, procedures, and pharmaceuticals, as outlined in member certificates and outlines of coverage. Even members with Blue Cross VT as a secondary carrier (including those with Medicare as the primary carrier) must obtain prior approval for applicable services.

> *Blue Cross VT has a Payment Policy CPP_20, “Use of Non-Network Providers,” which has certain requirements for Blue Cross VT contracted providers. Financial penalties may be applied if these requirements are not met. The complete policy is located on our provider website under Provider Policies, Provider Payment Policies.

The Blue Cross VT prior approval list is updated monthly. The FEP prior approval list is updated as of January 1 each year. The current lists are available on our provider website under Prior Approval Authorization.

Requests for prior approval can be submitted using the online Prior Authorization Portal or by fax. Prior authorization requests may be submitted by the referring provider,* the servicing provider, or the member. Paper forms can be obtained on our provider website under Prior Approval Authorization 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 receipt of the information. If no additional information is received by Blue Cross VT by the stated deadline, we will deny the request for benefits as not medically necessary based on the information 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 is 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 and Blue Shield Association TEC Assessment
- Blue Cross and Blue Shield Association Medical Policy Manual
- Blue Cross and Blue Shield of Vermont Medical Policy Manual
- Medical director review of current scientific literature
- Review of specific professional medical and scientific organizations, (e.g.,. SAGES)
- Milliman Care Guidelines (MCG), Current Edition

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

- A statement of the reviewer's understanding of the request;
- 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;
- If the review resulted in authorization, a clear and complete description of the service(s) that were authorized and all applicable limits or condition;.
- If the review resulted in adverse benefit determination, in whole or in part, the following is also included:
    - The specific reason for the adverse benefit determination, in easily understandable language;
    - The text of the specific health benefit plan provisions on which the determination is based;
    - 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;
    - 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;
    - 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;
    - A description of grievance procedures and the time limits applicable to such procedures;

- 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;
- 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;
- Notice of the right to request independent external review after a grievance determination, in the language, format and manner prescribed by the Vermont Department of Financial Regulation (DFR); and
- Local and toll-free numbers for the DFR'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 a 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 the provider contract for 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 Blue Cross VT and are eligible through our medical policy "Dental Services Pediatric (Qualified Health Plans and Applicable Plans"). Located on this link: www.bluecrossvt.org/providers/provider-policies under the Vermont Medical Policies link. These prior approvals 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 Blue Cross VT.
- **Radiology** prior approvals for Blue Cross VT members and New England Health Plan and Access Blue New England members (with an assigned VT PCP)are reviewed by Carelon Medical Benefits Management. Radiology prior approvals for Federal Employee Program are reviewed by Blue Cross VT.

TIPS on Prior Approval Requests:

- Make sure you submit a PA request for a service that requires PA prior to the service being rendered and to the right entity (Blue Cross VT, Carelon, Vermont Blue Rx). Use the PA lists posted to our website to ensure the service requires PA.
- Preferred method of submission is through our on-line Prior Authorization Portal, uploading the supporting clinical information. If you need assistance with the on-line Prior Authorization Portal, contact Provider Relations are providerrelations@bcbsvt.com or (888) 449-0443 option 1. If you are unable to use the on-line Prior Authorization Portal, requests can be sent by fax, using a State of Vermont Uniform Medical Prior Authorization Form, including supporting clinical information to (866) 387-7914.
- Regardless of method, ensure the PA details are filled out completely, and it is submitted with all the necessary clinical information to review the service.
- Provide a phone number (including any extensions, or useful information) that allows our staff to connect directly with the submitter if additional information is needed.

"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 individual's 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
- The most appropriate time to mark a request as "urgent" will be in situations involving urgently needed care (as defined by state regulations).
- 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.

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 Blue Cross VT.

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, do 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.

What does an Approved Prior Approval Mean

Approved prior approvals do not guarantee benefits or payment.

If you have an approved prior approval request it means that the proposed service(s) to be rendered meets expected medical criteria and is eligible for consideration of benefits.

Approved prior approval requests, upon receipt of the claim, are subject to provider contract terms, provider payment policies, claim editing solutions, and member benefits.

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 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 provider has already rendered the service 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.

Act 111 –Primary Care Provider (PCP) waiver of Prior Authorization

A claim submitted identifying the ordering provider on the claim form (see Section 12 for details) denies for lack of prior approval and the rendering provider had believed the ordering provider and member qualified for a waiver of prior approval. However, later it was learned that the provider was not a PCP, and/or the member did not qualify.

> Note: Retrospective prior authorization consideration will not be given to claims that did not report the ordering provider information correctly (or at all) on the claim form or electronic submission. See Section 12 of our on-line Provider Handbook for submission details. In these cases, a correct claim must be submitted with the ordering provider's information.

Ambulance Non-Emergent Transportation

- All instances where prior approval was not requested before services were rendered. The provider must contact us within a reasonable time, not to exceed 90 calendar days.

Chiropractic Services:

- Chiropractic services rendered within three (3) days of visit following the 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 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 Blue Cross VT coverage
- Provider not aware member had a change in Blue Cross VT 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.

Durable Medical Equipment (DME) 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.

- DME supplied as part of the inpatient discharge planning and discharge planning occurred during Blue Cross VT non-business operating hours.
- Continuation requests within 30 calendar days of the last covered day of the trial authorization for 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.

Monitored Anesthesia

- Requests received within 5 business days of the date of service.

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 Blue Cross VT and/or Delegated Vendor Partners

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

Requesting a Retrospective Review

If a provider identifies a service that qualifies for a retrospective review, they must submit a prior approval form noting it is a retrospective review and include 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.

Case Management for Care Coordination

When the provider and Blue Cross VT work together to help coordinate the care of our members, there may be times when we need to access members' PHI. Members do not need to provide authorization for this use of their PHI.

Blue Cross VT is committed to respecting the privacy of our members' Protected Health Information (PHI), and as a Covered Entity under HIPAA, we do not use or disclose a member's PHI unless either HIPAA's Privacy Rule permits or requires such disclosure, or the member who is the subject of the PHI authorizes such use or disclosure in writing. The Privacy Rule specifically permits the use and disclosure of a member's PHI for the purpose of that member's case management and care coordination. This permitted use allows us to safely work together with providers to help facilitate a member's case

management and care coordination needs. (*See* 45 CFR §§ 164.501, 164.502(a)(1); *see also* https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html and https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/disclosures-treatment-payment-health-care-operations/index.html.)

There are three options to refer a member to case management. Either the member or the provider can initiate this referral:

- Complete the following form on our website: https://secure.bcbsvt.com/referral.php
- Email our team at IHMTriage@bcbsvt.com. At a minimum, the email must include the member name, date of birth, and phone number where they can be reached. Note: emails should always be sent through a secure method.
- Call (800) 922-8778, option 3

Section 5

Blue Cross VT 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 Provider Policies:

- Accessibility of Service and Provider Administrative Standards
- Ancillary Provider Credentialing Policy
- Availability of Network Practitioners
- Clinical Practice Guidelines
- Facility Credentialing Policy
- PCP Selection Criteria
- Practitioner Credentialing Policy
- Provider Appeals from Adverse Contract Actions and Denials of Participation in Blue Cross VT Networks (name is different)
- Provider Contract Termination
- Quality of Care and Risk Investigations
- Site Visit and Medical Record Keeping

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.

We support the VT FIT Project through defraying the cost of the software license and the manuals, funding training, and creating an enhanced reimbursement for those providers participating in the project. The project is part of a Blue Cross VT 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 Blue Cross VT or VCC through the online software.

For more information on the VT FIT project, please contact Kristin Fletcher at fletcherk@bcbsvt.com .

Section 6

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

Billing of Members/Balanced Billing Reminders

Surcharges and Convenience Fee - Providers must have a fee-free way to collect member liabilities, regardless of whether a member is using a check, credit card, or debit card. Further, Providers may not impose credit card surcharges or other fees on members using either a personal debit card or an HSA/HRA issued debit card. A member should never be responsible for any additional fees beyond their reported liability.

Covered Services: Contracted providers accept the fees specified in their contracts with Blue Cross VT 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 the correct collection amount either through the eligibility tool on the Provider Resource Center, or by calling customer service. Providers may bill members up to the allowed amount or the 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 turnaround in refunding the member any amounts due must occur.

Note: FEP members who have original Medicare as their primary payer have some cost shares waived. Contact the FEP customer service team for specific details.

Non-Covered Services: Members may be billed up front for non-covered services. However, if the billed amount will be $500 or greater a waiver must be secured – see details under in "*Waiver (Informed consent)"* later on in this section.

Member Voluntarily Opting to Self-Pay (post service, claim submitted): If a member requests to have a previously submitted/processed claim voided, the provider or member must contact the appropriate customer service team for coordination. In addition, the provider needs to secure an informed consent waiver from the member. The waiver should meet the waiver requirements defined in this handbook with the addition of language stating the member is aware they are opting to have the services recovered, not billed to Blue Cross VT and that the member understands that the service(s) are an eligible benefit through their insurance and that they, the member will be held financially liable for the services (which are the actual billed charges, not the insurance allowance). Once the informed consent waiver is in place it needs to be included in the medical chart and a voided claim submitted to Blue Cross VT to have the services recovered. If the member nevertheless requests the claim be submitted after timely filing requirements have been exceeded, the claim should not **under any circumstances** be submitted.

Member Voluntarily Opting to Self-Pay (pre-service, prior to claim submission): If a member requests to self-pay for services and not use their health insurance, we recommend the provider secure an informed consent from the member and include it in their medical chart. The waiver should meet the waiver requirements defined in this handbook with the addition of language stating the member understands that the claim will not be billed to Blue Cross VT. If the member nevertheless requests the claim be submitted after timely filing requirements have been exceeded, the claim should not **under any circumstances** be submitted.

Member Liability Collection and/or Missed Appointment Policies: The provider must post or otherwise 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 Blue Cross VT. Supporting documentation related to the incident needs to be noted in the members' medical records.

Waivers (Informed consent): Services or items provided by a contracted/network provider that are considered by Blue Cross VT to be (terms are defined in the member's certificate of coverage) (1) investigational, (2) experimental, (3) not medically necessary, (4) non-covered over $500 (billed charges), or (5) Durable Medical Equipment "upgrades" 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 Blue Cross VT considers the service or item to be investigational, experimental, or not medically necessary; or (b) Blue Cross VT has issued an adverse determination letter for a service or item requiring prior approval; or (c) the provider has been routinely notified by Blue Cross VT 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 by phone, but must convey that the service will not be reimbursed by their insurance carrier, and they will be held financially responsible for the service.

3. The complete cost of the service has been disclosed to the member along with any payment requirements, and a waiver accepting financial liability for those services has been signed by the member and provider prior to the service being rendered. The waiver must clearly identify all costs (broken down by service) 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 Blue Cross VT. This allows the member to have a record of processing for his/her files, and if he/she has an HSA or other health care spending account, to file a claim.

NOTE: Services a member can never be billed for, even if a waiver is secured: (1) lack of prior approval, (2) duplicate claims, (3) timely filing, (4) claim edits (such as inclusive, mutually exclusive), (5) unlisted procedure, service or supply codes that have denied for a lack of description or documentation (see Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes" for details), (6) services not allowed through Provider Payment Policies (unless otherwise noted) and (7) services not eligible per provider contract (unless otherwise noted).

Waivers for Hearing Aids: Our expectation is that a practice is able to provide at least one hearing aid option for each eligible V code that is at or below our standard allowance.

If a member opts for a model that is above the standard option an informed consent (following the *"Wavier"* process defined above) must be obtained for the member to be financially responsible for the difference between our allowed amount and your billed charge.

If the member opts for a model that is not eligible per the providers contract (i.e., it is not on the list of eligible hearing aids) an informed consent (following the *"Waiver"* process defined above) must be obtained for the member to be financially responsible for the full charge of the hearing aid.

If an informed consent is not obtained for either of the situations above and the member files a complaint with us, a practice will be expected to write off the difference between our allowance and the billed charge.

Please refer to Section 6.7 under Hearing Aids and Related Services for more details.

Waivers for Provider Travel: Our member Certificate of Coverage does not provide benefits for non-medical charges including provider travel (e.g., time, mileage, and/or costs). However, your provider contract allows you to provide non-covered services to our members and bill them directly if they first sign a waiver that indicates:

1. exactly what the non-covered service is,
2. a good faith estimate of what the charge will be, and
3. a clear statement that the service(s) will not be covered by health insurance and they will be personally responsible for payment in full.

Do not submit a claim for this service.

Appeal Process

An appeal may only be filed by a provider when there has been a denial of benefit-related services for reasons such as non-covered services pursuant to the Member Certificate; services are not medically necessary or investigational; lack of eligibility; reduction of **benefits** (not a claim editing reduction); or unlisted procedure, service or supply codes that have been through a review and denied.

Before an 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 Appeal process.

When submitting an appeal request, you must include the member's name, date of birth, member policy identification number (ID number), date(s) of service, charge amount of the claim, and any clinical prior to the procedure that supports the medical necessity of the procedure (not just the results of the procedure). Only relevant clinical that supports the medical necessity of the procedure should be submitted, not the patient's entire medical record.

Note: Denials for (1) lack of prior approval, (2) duplicate claims, (3) timely filing, (4) claim edits (such as inclusive, mutually exclusive), (5) unlisted procedure, service or supply codes that have denied for a lack of description or documentation (see Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes" for details), (6) services not allowed through Provider Payment Policies (unless otherwise noted) and (7) services not eligible per provider contract. Do not file appeals for these denials.

Level 1—A First Level Appeal: A first level 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 Blue Cross VT. All information submitted during prior approval or claim submission processes will be automatically included in the appeal.)

Assuming you have provided all necessary information, the appeal will be decided within the time frames below, based on the type of service:

- 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 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, 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 with the reviewer(s) for your second level appeal. 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 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. The member must complete and sign the Vermont Department of Financial Regulation's "Request for Independent External Review of a healthcare decision" form authorizing you to represent them in the external appeal process. 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 receiving 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 a BlueCard Provider Claim Appeal Form located on the provider website under Provider Forms & Resources, Administrative Forms and Templates. If a 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 Blue Cross VT. Please note, the Blue Cross VT

BlueCard Appeal 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.

There is also a Universal BlueCard Appeal Form available for submission; however, not all the appeal reasons listed on the form are applicable to Blue Cross VT contracts.

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. Services included: 90785, 90791, 90792, 90832, 90834, 90837, 90846, 90847, 90853, 90863, H0015 and H0020. Effective January 1, 2026, the following codes were added in addition to the ones above: 99446, 99447, 99448, 9949, 99451, 90839 and 90840

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 Blue Cross VT 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 Blue Cross VT policy has an office visit co-payment for $20 and the secondary Blue Cross VT 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 preventive (non-ACA) employer benefits or do not take a co-payment.

- Preventive care (non-ACA) follows the traditional Blue Cross VT preventive guidelines
- ACA preventive has specific benefits that are defined in our "Preventive Care Guide," which is available on bluecrossvt.org/members.

To determine if a member has a preventive care (non-ACA) 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.

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: Blue Cross VT 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 Blue Cross VT) 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 member's 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 met as of the last day of June, services received from July—December can be billed to the member at the provider billed amount. If the member still has coverage in January of the following year, the benefits will renew, and member liabilities will only be up to the standard allowance.

You do not need to have a member sign a waiver. However, please do remind members when they are near their visit maximum so that they are financially prepared and do not receive unexpected bills.

You are not obligated to bill insurance once a benefit maximum is met, however, there are benefits to doing so:

- If you bill, your voucher and the member's *Summary of Health Plan Payments* (SOHPP) will show that you may bill the member up to the charged amount, so they will be aware that you are no longer obligated to accept the Blue Cross VT allowance.
- Most of our members have flexible spending accounts, Health Savings Accounts, or Health Reimbursement Accounts which cover certain medical expenses when they have no health insurance coverage available. In order to use the funds in these accounts for eligible services, the member will need the health insurance denial.
- If the member has some claims adjusted or recovered, resulting in more benefit dollars becoming available, the claim will process to the member's benefits.

NOTE: Benefit maximums are based on a member. If a member terminates their coverage and then reenters into coverage later in the plan year/calendar year, the benefit maximum will not reset until the new plan year/calendar year. It is very important to verify eligibility and benefit maximums before rendering any services.

For example: Member has a calendar year policy. They are effective January 1 but cancel for June 1. They have used 20 of their physical therapy benefit. They reenter into the contract on September 1. They have still used 20 of their physical therapy benefit and it will not reset until January 1.

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 Blue Cross VT, following the Blue Cross VT paper claim submission or the 837 companion guidelines. These are available on our provider website under Provider Electronic Payment.

- 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
        - Please note, the content of the email is not retained or reviewed
    - Mail to BCBSVT, PO Box 186, Montpelier, VT 05601-0186
- 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.

Industry Standard Procedure Codes: Services must be reported using the industry standard coding of Current Procedural Terminology™ (CPT®) and/or Healthcare Common Procedure Coding Systems (HCPCS).

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 provided through an eNewsletter advising of 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 eNewsletter is published at least two weeks (10 business days) prior to the effective date. If a situation arises where we are not able to provide the two weeks (10 business days) advanced notice, at a minimum a notice will be posted to the Recent News area advising of the status.

Unlisted Procedures, Services or Supply Codes: See details in Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes".

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.
- Claims with more than 12 diagnoses:
    - If there are more than 12 diagnoses, submit a second claim using code 99499 and bill a $0 charge (or $.01 if your system cannot support a zero charge) on the additional claim. Include the additional diagnosis codes that went beyond the maximum codes allowed from original claim on this new claim.
      IMPORTANT: 99499 must be the only code on this claim.
    - If appropriate, submit remaining diagnoses using code 99499 with modifier 25 and bill a $0 on the additional claim.
    - Code 99499 will show as denied/rejected for payment on the 835/provider voucher; however, we will still capture the diagnosis codes affiliated with this procedure code.

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

Claim Filing Limits

New Claims:

- Must be submitted and **accepted** into the Blue Cross VT claim processing system* not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) unless stated otherwise in the provider agreement.

  *Electronically submitted 837 claim files that are denied back to a vendor/clearinghouse are not considered accepted into the Blue Cross VT system.

  *Paper claims that are returned to the provider through the US Postal Service are not considered accepted into the Blue Cross VT system.

- If another payer is primary, claims must be submitted not more than 180 days from the date of the primary carrier's processing.

- If Blue Cross VT is primary, but the provider has another carrier on file and submits to that carrier as primary, the other insurance explanation of benefits must have a processing date not more than 180 calendar days of the date of discharge (inpatient) or from the date of service (outpatient and professional), and in processing reflect the member was eligible during the date of service. If these requirements are met, claims can be considered for benefits.

Claims submitted after the expiration of the 180-day calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) will be denied for timely filing and cannot be appealed or billed/collected from the member.

Adjustments and Corrected Claims:

- Adjustments and corrected claims must be submitted not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims), unless stated otherwise in provider agreement.

Adjustments/Corrected Claims

Adjustments and corrected claims must be filed not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) unless stated otherwise in the provider contract. DO NOT submit adjusted/corrected/late claims until you receive the original (or most recently submitted) claim processing on a provider voucher.

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

An adjusted/corrected claim is one which is processed through to an 835 or provider voucher but requires a specific correction such as, but not limited to, change in units, change in date of service, billed amount or CPT®/HCPCS code. Corrected claims can be submitted for any claim type (CMS 1500 or UB 04).

Adjustment/Corrected claims for Unlisted Procedures, Services or Supply Codes have very specific requirements. You will need to follow the instructions below and then see section 6.7 under Unlisted Procedures, Services or Supply Codes – Corrected Claims for full details of what to include.

Our preference is to have corrected claims submitted electronically using an 837 transaction. Please see our online 837 companion guides for details. Please note – we do not accept "corrected claims" those with a claim frequency type of 6 to be submitted electronically. Instead, we require a claim frequency code of 7 replacement of prior claim.

If you are not able to submit electronically, corrected claims can be submitted by "paper" through fax or email following the instructions below.

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.

To Submit a "paper" Corrected Claim:

- Print out the claim, including all original charges*
- Make changes to the area(s) of the form that requires correction
- Circle the area of the claim that has been changed
- Clearly note "CORRECTED CLAIM" at the top of the form
- If you have the original claim number**, please indicate it on the corrected claim next to the "corrected claim" notation. This will help expedite processing.
    - NOTE: Professional claims (CMS 1500) form locator 22 can be populated with information, HOWEVER, the instructions in the bullets must be followed, or the claim will be returned.

- If the corrected claim is for a member who has other insurance as primary, the primary carriers EOB must be included with the corrected claim.

*Do not include service line(s) the claim editing software may have added to the original claim processing; report only those lines you originally submitted.

**Split claims (broken out into fee for service and capitation) need to report the fee-for-service claim number (FFS claims do not have the 5 after the Julian date.)

Methods of Submission for Corrected Claims

- **Fax:** Fax each corrected claim with a separate cover sheet/letter to (802) 371-3365. Cover sheet/letter must clearly identify:
    - The name and contact information of the person submitting the request
    - Name and contact information of person to follow up with (if not the submitter)
- **Email:** Email in a secure format as an attachment with cover letter (if applicable) to correctedclaims@bcbsvt.com

Information contained within the email itself will not be retained. Make sure all information is either in the cover letter or written on the corrected claim.

Technical Details

- Only one claim per email
- Individual files must be less than 10 MB
- Image formats accepted are PDF, TIF, JPG, BMP, PNG
- Submit via secure email

If there are any questions, we will reach out directly by phone or fax.

Reminders

- Submit **only** corrected claims or Inpatient DRG late charges (Type of Bill 115).
- Do not submit clean claims, late charges (other than DRG late charges as indicated above), or any inquiry that requires a response using this process.
- Claims that require a complete recovery can be handled by calling our customer service team, submitting a provider overpayment form, or submitting an 837 HIPAA-compliant transaction.
- Be sure to retain your fax or email confirmation.
- Please allow 30 days for the corrected claim to process.
- The status of the corrections will be reflected under 'Claim Status Inquiry' on our Provider Resource Center.
- Notice of final processing of the corrected claim will appear on the 835 and/or provider voucher.
- Corrected claim information is not accepted over the phone. It does require submission using one of the above methods.
- Claims that processed and denied through a claim edit may only be submitted as a Corrected Claim when a modifier is being added or a procedure code changed.

Diagnosis Changes on Corrected Claims

Blue Cross VT claims process using the first diagnosis code submitted. If you receive a denial related to a diagnosis code on a Blue Cross VT claim and there is another diagnosis on the claim that would be eligible, you do not need to submit a corrected claim; just contact our customer service team either by phone, email, fax or mail and they will initiate a review and/or adjustment. Or, if the diagnosis is truly in the wrong position, you may submit a corrected claim updating the placement of the diagnosis.

For BlueCard claims, we send all reported diagnosis code(s) to the members' Plan. 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.

Interest Payments

For qualifying claims, Vermont law (18 V.S.A. § 9418(e)) governs the payment of interest, based upon the amount paid by Blue Cross VT in accordance with Vermont law.

NOTE: Federal Employee Program claims are not subject to interest payments at any time.

Claim Submission when Changing from Contracted to Non-Contracted and Vice Versa

If your status changes from contracted to non-contracted or vice versa, you must bill separate claims for dates of service that overlap. Our system determines contract status based on the first date of service reported on a claim. For example, if you start contracting November 1, dates of service prior to November 1 need to be billed on a separate claim from/transaction from services provided November 1, or after.

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 Blue Cross VT. We have created the guides below to assist you.

Notes: If you are an ancillary or remote provider, refer to the section further on in this handbook.

Claim Submission Guidelines for
Providers Contracting with Both Blue Cross VT and BCBS Massachusetts Plans

Product Type	State Services Rendered In	Primary Care Provider State	Submit claims to
Blue Cross VT prefixes	Massachusetts or Vermont	N/A	BCBSVT
Federal Employee Program (R)	Massachusetts	N/A	BCBSMA
Federal Employee Program (R)	Vermont	N/A	BCBSVT
BCBSMA non-NEHP prefixes (all contracted prefixes)	Massachusetts or Vermont	N/A	BCBSMA
NEHP PCP Rendered Services*	Massachusetts or Vermont	Massachusetts	BCBSMA
NEHP PCP Rendered Services*	Massachusetts or Vermont	Vermont	BCBSVT
NEHP PCP Rendered Services*	Massachusetts or Vermont	New Hampshire	BCBSNH
NEHP non-PCP Rendered Services*	Massachusetts	N/A	BCBSMA
NEHP non-PCP Rendered Services*	Vermont	N/A	BCBSVT
Blue Card (all non-NEHP prefixes)	Massachusetts	N/A	BCBSMA
Blue Card (all non-NEHP prefixes)	Vermont	N/A	BCBSVT
CBA Blue	Massachusetts or Vermont	N/A	CBA Blue

Key to Grid:

- **NEHP (New England Health Plans):** Refers to NEHP and Access Blue New England (ABNE) members.
- **Access Blue New England:** Open access product; referrals are not required.
- **PCP State:** Refers to the state with which the provider contracts as a PCP for NEHP members. NEHP providers can only act as PCPs with one state.
- **Prior Approvals:** Submit to PCP state (excluding radiology, prescriptions drugs and behavioral health) when the PCP contracts with Blue Cross VT (not managed by Blue Cross VT).
- **Prefix Listings:** Located on the provider website under Provider Forms & Resources, Claim Forms and Information.

*NEHP Border Provider Guidelines

- If a member is receiving services from their own PCP or covering PCP, claims should be submitted to the PCP Blue Plan.
- If a specialist participates with 2 Blue Plans and has 1 office, claims should be submitted to the Blue Plan where their office is physically located.
- If a specialist participates with 2 Blue Plans and has offices in 2 Blue Plans, claims should be submitted to the Blue Plan where services were physically rendered.
- If a specialist participates with only 1 Blue Plan and has offices in 2 Blue Plans, claims should be submitted to the Blue Plan where the provider is participating.
- If a facility participates with 1 Blue Plan, claims should be submitted to the Blue Plan where the facility is participating.
- If a facility participates with 2 Blue Plans, claims should be submitted to the Blue Plan where the services are physically rendered.

Claim Submission Guidelines for
Providers Contracting with Both Blue Cross VT and Elevance Health (formerly Anthem, Inc) BCBSNH Plan

Product Type	State Services Rendered In	Primary Care Provider State	Submit Claims To
Blue Cross VT prefixes	New Hampshire or Vermont	N/A	BCBSVT
Federal Employee Program (R)	New Hampshire	N/A	Appropriate Elevance Health (formerly Anthem, Inc) BCBSNH
Federal Employee Program (R)	Vermont	N/A	BCBSVT
Anthem NH non-NEHP prefixes (all contracted prefixes)	New Hampshire or Vermont	N/A	Appropriate Elevance Health (formerly Anthem, Inc) BCBSNH
NEHP PCP Rendered Services*	New Hampshire or Vermont	New Hampshire	Appropriate Elevance Health (formerly Anthem, Inc) BCBSNH
NEHP PCP Rendered Services*	New Hampshire or Vermont	Vermont	BCBSVT
NEHP PCP Rendered Services*	New Hampshire or Vermont	Massachusetts	BCBSMA
NEHP non-PCP Rendered Services*	New Hampshire	N/A	Appropriate Elevance Health (formerly Anthem, Inc) BCBSNH

NEHP non-PCP Rendered Services*	Vermont	N/A	BCBSVT
Blue Card (all non-NEHP prefixes)	New Hampshire	N/A	Appropriate Elevance Health (formerly Anthem, Inc) BCBSNH
Blue Card (all non-NEHP prefixes)	Vermont	N/A	BCBSVT
CBA Blue	New Hampshire or Vermont	N/A	CBA Blue

Key to Grid:

- **NEHP (New England Health Plans):** Refers to NEHP and Access Blue New England (ABNE) members.
- **Access Blue New England:** Open access product; referrals are not required.
- **PCP State:** Refers to the state with which the provider contracts as a PCP for NEHP members. NEHP providers can only act as PCPs with one state.
- **Prior Approvals:** Submit to PCP state, excluding radiology, prescriptions drugs and behavioral health when the PCP contracts with Blue Cross VT (not managed by Blue Cross VT).
- **Prefix Listings:** Located on the provider website under Provider Forms & Resources, Claim Forms and Information.

*NEHP Border Provider Guidelines

- If a member is receiving services from their own PCP or covering PCP, claims should be submitted to the PCP Blue Plan.
- If a specialist participates with 2 Blue Plans and has 1 office, claims should be submitted to the Blue Plan where their office is physically located.
- If a specialist participates with 2 Blue Plans and has offices in 2 Blue Plans, claims should be submitted to the Blue Plan where services were physically rendered.
- If a specialist participates with only 1 Blue Plan and has offices in 2 Blue Plans, claims should be submitted to the Blue Plan where the provider is participating.
- If a facility participates with 1 Blue Plan, claims should be submitted to the Blue Plan where the facility is participating.
- If a facility participates with 2 Blue Plans, claims should be submitted to the Blue Plan where the services are physically rendered.

Claim Submission Guidelines for
Providers Contracting with Blue Cross VT and New York Blue Plans

Product Type	State Services Rendered In	Submit Claims To:
Blue Cross VT prefixes	New York or Vermont	BCBSVT
Federal Employee Program (R)	New York	Appropriate NY Plan
Federal Employee Program (R)	Vermont	BCBSVT
Blue Card	New York	Appropriate NY Plan
Blue Card	Vermont	BCBSVT
CBA BLUE	New York or Vermont	CBA Blue

Key to Grid:

- **Appropriate NY Plan** (i.e., BlueCross BlueShield of Western New York, BlueShield of Northeastern New York, Empire Blue Cross Blue Shield, Excellus BlueCross and BlueShield (Rochester)
- **Prefix Listings:** Located on the provider website under Provider Forms & Resources, Claim Forms and Information.

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 may be re-directed to the PRC for self-service.
- In order for a third-party biller (or vendor) to receive written correspondence (such as notices, letters, or emails) from Blue Cross VT, 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 Blue Cross VT 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 Blue Cross VT 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.

Blue Cross VT 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 not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims) 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, Overpayments and Outcomes-Based and Coding Programs

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 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 Rawlings Company LLC to provide reviews on coordination of benefit (COB) claims. Rawlings 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 Blue Cross VT/TVHP claims:

- Duplicate services
- Claims suspected to have administrative billing and payment errors
- Medically unlikely units (MUE)
- Blue Cross VT observation services Payment Policy CPP_07
- Blue Cross VT provider-based billing Payment Policy CPP_11

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. We have a signed business associate agreement with Cotiviti Healthcare, so you may release the requested information to them directly. Please respond within the timeframe specified in the Cotiviti Healthcare request.

We perform pre-adjudication audits. Audits are conducted on all inpatient institutional (acute care) claims with total billed charges of $100,000.00 or more, excluding (1) inclusively priced (DRG and per diem), (2) Medicare Supplement, (3) Medigap and (4) traditional Medicaid claims. Blue Cross VT initiates the review and will request the itemized statement for the stay. Our audit partner, Claris Health, reviews the information and notifies the provider of findings, appeals, etc. We process the claim in accordance with the findings.

We also perform credit balance reviews. These are performed onsite by our partner, CDR Associates, retrospective provider credit balance reviews of all active Blue Cross VT accounts.

Focus of the review:

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

Overpayment:

When you detect an overpayment, please do not refund the overpayment amount to Blue Cross VT* or the patient. Instead, please complete a Provider Overpayment Form, available on the provider website under Provider Forms & Resources, Administrative Forms and Templates. 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 mailing a check

*For BlueCard® claim refunds more than 24 months past the claim's processing date, we may request a check (rather than recovering the funds) 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.

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. 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 on our provider website under Provider Forms & Resources, Administrative Forms and Templates. Claim Review requests must be made not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims). 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 Blue Cross VT 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 bluecrossvt.org/members.

Completed request forms for confidential communication must be faxed directly to the Blue Cross VT legal department secure fax line at (866) 529-8503; mailed to the attention of 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 Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT 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 our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides. 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 ecommercesupport@bcbsvt.com.

*Updated Companion Guides are posted to our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides.

Note: Claims requiring attachments must be submitted on paper. See Section 6.3 Paper Claims Submission *"Submitting Claims with Attachments"* for details.

General Electronic Data Interchange (EDI) Claim Submission Information

We use several vendors/clearinghouses to accept claims. All transactions received must be in an 837 HIPAA-compliant format. A list of clearinghouses is available on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides.

HIPAA-Compliant 837 Claim Submission (Electronic)

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

The following guides can be found on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and 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.

When you bill claims electronically for secondary submission (e.g., another carrier is primary—including Medicare or Medicare supplemental plans such as Medicare Advantage, etc.):

Professional Claims

- Loop 2000B—Subscriber Level Information
    - Segment SBR01 must report either a S (secondary), T (Tertiary) or U (unknown)
    - If the primary carrier was Medicare or a Medicare Advantage program
        - Segment SBR09 must report a MA or MB
- The other insurance claim processing details must report at the service line level. We will not accept claims that report the other insurance processing at the claim level.

Facility Claims

- Loop 2320—Other Subscriber Information
    - If the primary carrier was Medicare or a Medicare Advantage program
        - Segment SBR09 must report a MA or MB
- For all claim types except inpatient claims, the other insurance claim processing details must report at the service line level. We will not accept claims that report the other insurance processing at the claim level.

Electronic claims submitted with errors need to be corrected and resubmitted electronically. We will not adjust incorrect electronic claims.

Our complete 837 companion guides are located on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides.

As a reminder, 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 of Medicare primary claims are not required, including claims CMS classifies as “Mass Adjustments.”You should only submit a Medicare primary claim for processing if it has been at least 30 days since

Medicare processed and you have not received processing from us. For details about the COBA program, see Section 6.6. of this Provider Handbook.

***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)
    - Facility—15 characters
    - 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.

Section 6.3

Paper Claim Submission

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 Blue Cross VT variances are posted to our provider website under Provider Forms & Resources, Claim Forms and Information:
    - 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. Claims with missing or inaccurate information 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, depending 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.

How to Avoid Paper Claim Processing Delays

Please avoid the following to promote faster claim processing:

- Lower-case alpha prefix or alpha characters in an identification number. These 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 details.)
- Modifiers requiring documentation, such as modifier 22, 62, or 66 (please refer to modifier section below for more information).
- Unlisted Procedures, Services or Supply Codes must be submitted with office and/or operative notes (medical notes) and include a written description of the service that was rendered and billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. See Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes" for full details.
- Waiver (Informed consent) for BlueCard members hearing aids or related services. See Section 6.7 under Hearing Aids and Related Services for details.

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 not reported as capital letters. Lower case are not easily read by our scanners
- CMS 1500 form, item/block number 6—Patient's Relationship to Insured: If the patient relationship is reported as "self" but the Patient's Name (item/block number 2) reports a name that is different than the Insured's Name (item/block number 4), the claim is returned to the provider for correction of either:
    - Patient's relationship to insured (item/block number 6), or
    - Patient's name (item/block number 2).

  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:

Code	Title
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Section 6.4

ClaimsXten-Select™, Cotiviti, Inc., and Clear Claim Connect (C3)

ClaimsXten-Select™ and Cotiviti, Inc.

We utilize ClaimsXten-Select™ software and Cotiviti, Inc., clinical claims editing software to facilitate accurate claim processing for claims and services provided to members of Blue Cross VT commercial health plans.

An overview of ClaimsXten-Select™ and Cotiviti, Inc. edits that are applied are located in our Payment Policy CPP_32, "Claims Editing—ClaimsXten-Select™ and Cotiviti, Inc. Edits Payment Policy" . The policy as well as the process to submit questions related to coding denial(s) are located on our provider website under Provider Policies, Provider Payment Policies.

Coding Tip Sheets are posted to the provider website https://www.bluecrossvt.org/providers/provider-forms-resources, Provider Forms & Resources under Coding Tip Sheets.

Members cannot be billed for services that deny due to ClaimsXten-Select™ and Cotiviti, Inc., edits, even if a waiver is secured. These denials are a provider's liability.

Exceptions to Editing Logic

- Behavior Change Interventions (*ClaimsXten-Select™ Logic)*
    - 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
    - Code 99050 is not subject to any code editing logic. See "After Hour Services" below.

Upgrades to ClaimsXten-Select™ and Cotiviti, Inc. Logic

The ClaimsXten-Select™ software is upgraded quarterly (January, April, July and October).

Cotiviti, Inc., software is updated regularly, frequency has yet to be determined.

ClaimsXten-Select™ and Cotiviti, Inc., edits are applied based on date of processing, regardless of date of service. Claims processed prior to an upgrade that require an adjustment will be subject to the upgraded ClaimsXten-Select™ or Cotiviti, Inc. edits, regardless of the date of service.

Edits are not retroactively applied to the ClaimsXten-Select™ or Cotiviti, Inc. edits. Any changes take effect as of the upgrade date.

ClaimsXten-Select™ and Cotiviti, Inc. Logic Review

A ClaimsXten-Select™ or Cotiviti, Inc. edit review is a request by a provider for review of the edit logic supporting the processing of claims.

Notes:

- 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.
- For a Cotiviti, Inc. review, processing of the claim should be reviewed against our Payment Policy CPP_32, "Claims Editing—CLAIMSXten-SELECT™ and Cotiviti, Inc. Edits Payment Policy" located on our provider website under Provider Policies, Provider Payment Policies.

Details on how to file a review request is located on our Provider Policies page, under Payment Policies, Claim Editing – Process to Submit Questions Related to Coding Denial(s).

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.

Coding Resources:

Coding Tip Sheets are located on our provider website https://www.bluecrossvt.org/providers/provider-forms-resources under Provider Forms & Resources, Coding Tip Sheet.

Clear Claim Connection™ (C3)

C3 is a web-based application that enables us to disclose **coding rules and edit rationale*** to our provider network. *This tool only provides details of ClaimsXten-Select™ edits.* Providers may access the C3 tool 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)

Descriptions of these edits are available in our claims editing Payment Policy CPP_32, "Claims Editing—CLAIMSXten-SELECT™ and Cotiviti, Inc. Edits Payment Policy" located on our provider website under Provider Policies, Provider Payment Policies.

Using the C3 tool:

- Go to the Blue Cross VT provider website: bluecrossvt.org/provider.
- Sign into the Provider Resource Center.
- Click on "Claim check analysis via the Clear Claim Connection™ (C3)."
- Review and accept terms and conditions.
- Complete the following fields (unless noted otherwise):
    - Claim type
        - Professional
        - Facility (outpatient)
        - Facility (inpatient)
    - Gender
        - Male (default selection if nothing is chosen)
        - Female
    - Date of Birth in mm/dd/yyyy format
        - Must be less or equal to date of service
    - ICD Code Set—this is an optional field
    - Diagnosis—this is an optional field
    - Bill Type
        - Field pre-populates only if facility claim type was selected
            - Outpatient—131
            - Inpatient—111
    - Claim Line Fields (at least one claim line must be completed)
        - 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
- Click Review Audit Results Button or press Enter for results
- To bring up an empty entry screen, click 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 C3 Results: 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 claims or member data. To get an accurate result from a C3 review, you will need to enter all services provided. For example, if an office visit occurs a day earlier than a surgery, enter the office visit and date as well as 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.

Rawlings Company LLC administers subrogation, workers' compensation and coordination of benefits for Blue Cross VT.

- 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: mark "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 on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides.

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

For FEP, please refer to the FEP section in this handbook.

Coordination of Benefits (COB)—Members with More Than One Blue Cross VT Policy

Some members have more than one policy with Blue Cross VT. In these cases, the claim needs to be submitted to Blue Cross VT (electronically or on paper) under the primary insurance identification number with the secondary Blue Cross VT 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 Blue Cross VT crossed to the secondary policy.

Work-Related Injuries and COB

Injuries which are work related are an exclusion of our member 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.

Rawlings Company LLC administers subrogation, workers' compensation and coordination of benefits for Blue Cross VT.

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 that 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 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 from the date of service.

NOTE: If a claim contains services that were allowed by worker's compensation and services that were denied by worker's compensation, separate claims must be submitted. In order to process to benefits correctly, we need a claim with approved services and a claim with denied services.

If a claim is paid by the worker's compensation carrier and payment was also made by Blue Cross VT, you will need to request a recovery of the Blue Cross VT payment. The request can be by email to customerservice@bcbsvt.com. Please include your billing NPI number, member name, ID number, date of service and if you have it, the Blue Cross VT claim number. Please also attach a copy of the worker's compensation explanation of benefits. If you do not have the worker's compensation explanation of benefits, we will need the name of the worker's compensation carrier, their phone number, claim number, and any other details you may have related to the claim.

Exhausted Workers Compensation Benefits

Once the workers compensation benefit is exhausted, you must 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 claims are not required, including claims CMS classifies as "Mass Adjustments".

Exclusion: Claims for FEP members who reside in a state other than Vermont 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 (Blue Cross VT). In this case, the provider needs to submit the claim directly to us. If you are submitting on paper, please remember to include the 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 that we have the claim on file. This can be done via our Provider Resource Center 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 Blue Cross VT participating provider and payment is due, an 835 is generated and forwarded to Blue Cross VT 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 crossover, you will need to submit a claim to the member's Blue Plan directly. Claim submissions can be on paper or electronically. If you submit a paper claim, please remember to include a copy of the Explanation of Medicare Payment.

Blue Cross VT does not accept Medicare adjusted claims for other Blue Plan members.

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 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 attach 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.
    - 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.
    - If you are submitting the correction on paper, be sure to include the EOMP.

Claims Where Medicare Is Primary and a Reported Revenue Code does not have a HCPCS Code, however, Blue Cross VT requires a HCPCS Code

Claims crossed over to Blue Cross VT for consideration of benefits after Medicare will process as follows:

- Supplemental Policy – will process according to members benefits
- Secondary Policy – the claim will process and deny those service(s) line that require a HCPCS code and do not have one reported. You will need to submit a corrected claim, including a HCPCS code on those line(s) and if paper, including a copy of the MEOB. If submitted electronically, the line level details of Medicare processing must be reported. The Medicare processing cannot be at the claim level.

If you have a claim that did not cross over from Medicare and you are submitting for consideration of benefits, make sure to include the HCPCS code on the original claim submission. In addition, a copy of the MEOB must be included if the submission is on paper. If submitted electronically, the line level details of Medicare processing must be reported. The Medicare processing cannot be at the claim level.

Blue Cross VT Contracted Providers Not Participating with Medicare or Opting Out of Medicare

Providers may participate with Blue Cross VT 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 Blue Cross VT secondary coverage can be complicated. Here are some general guidelines:

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 the Blue Cross VT 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 Blue Cross VT policy) not collected at the time of service. Please note, however, that for Blue Cross VT members with secondary benefits, the ceiling for payment is the difference between what Medicare paid and Blue Cross VT'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 Blue Cross VT policy) not collected at the time of service. Please note, however, that for Blue Cross VT members with secondary benefits, the ceiling for payment is the difference between the amount Medicare paid and Blue Cross VT'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 Blue Cross VT.

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 Blue Cross VT secondary coverage, and the services at issue are covered by Blue Cross VT, the provider should not collect from the member any amounts that exceed the applicable Copayment, Deductible, or Coinsurance amounts under the Blue Cross VT secondary policy. When billing us for a member with a secondary policy, the provider must submit the service lines with a modifier -GY*. 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 Blue Cross VT secondary plan does not cover, but the provider is bound to accept Blue Cross VT'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 Blue Cross VT 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 Blue Cross VT.

*This includes claims for FEP members.

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

See Section 7 BlueCard for details.

FEP and Medicare

See Section 9 FEP 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 under the Provider News & Updates link.

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 Provider Policies, Provider Payment Policies.

We reserve the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in Blue Cross VT 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 Blue Cross VT and TVHP.

*In accordance with 18 V.S.A. § 9418c contracted providers have the right to object to new or modified policies and manuals changes.

Providers who object must do so within 60 days of the date of notice related to a policy or manual change. The rationale for the objection to the change must be in writing including related area(s) of the policy or manual and rationale or reasoning for the objection.

These objections are to be directed to Provider Contracting. This can be done by email at: providercontracting@bcbsvt.com or US Postal Service BCBSVT Attn: Provider Contracting, PO Box 186, Montpelier, VT 05601.

Within 5 business days of receipt, the sender will receive confirmation of receipt of the objection.

Act 111 –Primary Care Provider Waiver of Prior Authorization
See Section 12 for details on billing requirements

Acupuncture
Our Payment Policy CPP_02 "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. Do not submit claims for in-eligible services.

Our Payment Policy CPP_02 "Acupuncture" is located on our provider website under Provider Policies, Provider Payment Policies.

*Note: State of Vermont Employer Group (prefixes EVT and FVT) can receive acupuncture services from any provider acting within the scope of their licensure and in addition, they have allowances for massage therapy rendered by a Blue Cross VT acupuncture provider. Massage therapy for these members is billable to Blue Cross VT and does not require the member to sign a waiver. Please verify members benefits prior to rendering services.

Add-On Codes

See Claims Editing—ClaimsXten-Select™ and Cotiviti, Inc. Edits Payment Policy CPP_32 located on our provider website under Provider Policies, Provider Payment 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, code 99050 is eligible for benefits and not subject to any claim editing logic.

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 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.

Age Related Service Codes:
See Payment Policy CPP_32 Claims Editing under "Age Code Replacement" or "Procedure Age" for details.

Age Related Diagnosis
See Payment Policy CPP_32 Claims Editing under "Diagnosis-Age Consistency" for details.

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

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

Ambulance
Report the ambulance pickup zip code on the claim submission.

Paper claims need to report the pickup zip code in item/block number 23. Electronic claims need to report the pickup zip code in loop 2310E.

Claims must be submitted to the Blue Plan where the member was picked up. Only pickup zip codes in Vermont can be submitted to Blue Cross VT. Any claim received without a Vermont zip code will be denied and must be submitted to the appropriate Blue Plan.

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

Ambulatory Surgical Center (ASC)
See Payment Policy CPP_32 Claims Editing for details.

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 details.

Assistant Surgeon
See Payment Policy CPP_32 Claims Editing for details.

Bevacizumab (Avastin)
The injectable medication bevacizumab (Avastin) should be billed using the code C9257 when used for ophthalmic indications. Each billing unit is for 0.25 mg of the medication. Prior approval is not required.

Code J9035, bevacizumab 10 mg for injection, should not be used for ophthalmic indications. If used, prior approval is required.

Bilateral Procedures
For bilateral procedures when there is no specific bilateral procedure code, use the appropriate 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—modifier 50 should be used only on the second line.

Also, see Payment Policy CPP_32 Claims Editing for details.

BiPAP Supplies
See Frequency of Supplies (Diabetic and CPAP/BiPAP) (CPP_33) in this section for details.

See Payment Policy CPP_32 Claims Editing for details.

Biomechanical Exam
Use office visit codes for biomechanical exams.

Blood (Device and Supply)
See Payment Policy CPP_32 Claims Editing for details.

Blood and Blood Components
We have a payment policy for Blood and Blood Components CPP_43. The policy is located on our provider website under Provider Policies, Provider Payment Policies.

Primary Care Provider Waiver of Prior Authorization (Act 111)
See Section 12 for details on billing requirements

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

Bundled Services (professional and facility)
See Payment Policy CPP_32 Claims Editing for details.

Clinical Trials
See Payment Policy CPP_32 Claims Editing under "Diagnosis Procedures" for details.

CMS Correct Coding Initiative
See Payment Policy CPP_32 Claims Editing for details.

CMS Unbundling
See Payment Policy CPP_32 Claims Editing for details.

Column Two Procedure with Column One Procedure Code
See Payment Policy CPP_32 Claims Editing for details.
We have a Coding Tip Sheet specific to this, located on our provider website https://www.bluecrossvt.org/providers/provider-forms-resources, Provider Forms & Resources under Coding Tip Sheets**.**

Colonoscopy
If a Blue Cross VT 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 one of the diagnosis codes below, 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, Z13.811, Z80.0, Z80.9, Z83.71, Z85.030, Z85.038, Z85.040, Z85.048, Z85.060, Z85.068, Z86.010, Z86.018, Z87.19

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

Consultations (Outpatient)
See Payment Policy CPP_32 Claims Editing for details.

Contraceptive Counseling or Management:
The diagnosis in the first position needs to align with those eligible diagnoses in our preventive grid located at: **www.bluecrossvt.org/documents/preventive-care-guide** under Preventive Gynecologic and Wellness Exam for Contraceptive Management. Contraceptive encounters are eligible for first dollar coverage (without member liabilities) when billed using one of the diagnoses listed in our Preventive Grid.

CPAP Supplies
See Frequency of Supplies (Diabetic and CPAP/BiPAP) (CPP_33) in this section for details.
See Payment Policy CPP_32 Claims Editing for details.

COVID-19 Administration and Vaccine
The appropriate COVID-19 administration code and vaccine code **must be** reported on the claim. If only the administration service is billed, the claim will deny.

When the vaccine is supplied free of charge from the federal government, the applicable vaccine code must be reported without a **modifier** (DO NOT bill a modifier -SL) and a zero charge, or if your system is not capable of a zero charge, $0.01 may be billed.

NDC codes are not required for the COVID-19 vaccine or vaccine administrations, however, will be accepted if submitted. The NDC must be a valid, active code and reporting must be per our NDC guidelines (see Section 6.7 for details).

The administration and vaccine will be considered for benefits without member liabilities. The vaccine is not eligible for reimbursement when supplied by the federal government.

COVID-19 Monoclonal Antibody Treatment
When billing for COVID-19 monoclonal antibody treatment (injection), the antibody itself must also be reported on the claim. For antibody codes that are not eligible for reimbursement, the applicable antibody code must be reported, without a **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.

Antibody treatment (injection) supplied by the federal government at no charge is not eligible for reimbursement.

Date of Service
Billing of advanced dates of service is not allowed. The date(s) of service reported on a claim cannot exceed the submission date. Exception – if Medicare is the primary carrier and allows for billing of advanced dates of service.

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

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

Designated Agencies (Vermont)

Our Payment Policy, Vermont Designated Agency (CPP_45) provides the policy, scope, process and billing for the Designated Agencies.

The policy is located on the provider portal under Policies, Provider Payment Policies.

Device and Supply (diagnostic and therapeutic)
See Payment Policy CPP_32 Claims Editing for details.

Device and Supply (drugs)
See Payment Policy CPP_32 Claims Editing for details.

Diabetic Supplies
See Frequency of Supplies (Diabetic and CPAP/BiPAP) (CPP_33) in this section for details.
See Payment Policy CPP_32 Claims Editing for 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—Blue Cross VT 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 Blue Cross VT 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.

See Payment Policy CPP_32 Claims Editing under "Diagnosis Code Guideline" and "Diagnosis Validity" for details.

Diagnostic Testing
See Payment Policy CPP_32 Claims Editing under "Professional, Technical, and Global Services" for details

Discarded Drugs and Biologicals (Professional and Facility) (formerly Drug Wastage)
See Payment Policy Discarded Drugs and Biologicals (Professional and Facility) CPP_47 for details.

Drugs Dispensed or Administered by a Provider in an office, outpatient*, ambulatory surgical center or home infusion setting (other than pharmacy)
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:

- Medical and Surgical Supplies (i.e., other supplies and devices; radiopharmaceuticals)
- Enteral and Parenteral Therapy
- Outpatient PPS (i.e., drugs, biologicals, and radiopharmaceuticals (carrier discretion to utilize outside scope of OPPS))
- Drugs administered other than oral method
- Chemotherapy Drugs
- Medical Services (intravenous Infusion)
- Pathology and Laboratory (i.e., miscellaneous)
- Procedures/Professional Services/Temporary codes (specific to Medical Rx only)
- Skin Substitutes/Bioengineered Skin
    - Exception: when code description indicates add-on list separately in addition to primary procedure OR list separately to primary procedure.

*Outpatient includes the following settings – hospital, psychiatric day care facility, specialized treatment center, comprehensive outpatient rehabilitation center, independent kidney disease treatment center, community mental health center and substance abuse facility.

The requirement does not apply to:

- Durable Medical Equipment
- COVID-19 vaccine, however, will be accepted if submitted. The NDC must be a valid, active code and reporting must be per our NDC guidelines.
- Flu vaccine, however, will be accepted if submitted. The NDC must be a valid, active code and reporting must be per our NDC guidelines.

Claims submissions must be complete and accurate, meeting the requirements of our guidelines, or the applicable service(s) will be denied. If you receive a denial, the member cannot be held liable (even with a signed waiver), and a corrected claim can be submitted for consideration of benefits.

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

Unit of Measure	Description
F2	International Unit
GR	Gram
ME	Milligram
ML	Milliliter
UN	Unit

Paper Claims:

CMS 1500 form - refer to our online CMS Form Instructions (item/block number 24a in shaded area and 24d) located on the provider forms resources page under claim forms and information.

ADA form – report the below in the remark field, if the form does not have a remark field report at the top of the claim.

N4, 11-digit NDC (no hyphens), unit of measure and quantity (limited to 8 digits before the decimal point and 3 digits after the decimal point).

Example: N400023923201UN100

UB-04 form – refer to our online UB-04 Paper Claim Billing Instructions (form locator 43, 44 and 46) located on the provider forms resources page under claim forms and information.

Electronic Claims: HIPAA compliant 8371 or 837P refer to the companion guide (Loop – 2410 – Drug Identification).

We have posted a National Drug Code (NDC) Provider Tool that will assist practices in determining the unit of measure that needs to be reported. It is in two locations:

- The **Provider Resource Center** under the Tools and Resources link.
- At www.bluecrossvt.org/providers/provider-forms-resources under National Drug Code (NDC) Information and Resources.

Drug HCPCS Level II Billing

To be properly paid for drugs dispensed or administered by a provider in an office, outpatient or home infusion setting (other than pharmacy) it is important not to assume that units billed equal the amount administered. The Healthcare Common Procedure Coding System (HCPCS) Level II codes that describe drugs are very specific in their descriptors about the drug quantity that equates to a single unit, noting each code is specific based on the unique code descriptor.

A common mistake involves billing by the number of units administered rather than reporting the number of units represented by the HCPCS Level II code descriptor. Here are a few examples to ensure when assigning units billed for accuracy based on code description.

Billing Drug Units (UN Qualifier)

Example 1: **[Drug Z]**

HCPCS Level II Descriptor	**J1234** [Injection, **Drug Z**, 7.5mg
Unit of Measure (UM)	7.5mg is equal to 1 (UM) based on the HCPCS Level II code descriptor reported
Dose Administered (DA)	22.5mg
Correct Units Billed Calculation	Calculation: (DA [22.5mg] ÷ UM [7.5mg]) = 3 Units Billed
Incorrect Units Billed	22.5mg (Based on the reporting of the HCPCS Level II descriptor) which 1 (UM) equals 7.5mg **NOT** 22.5mg
(National Drug Code (NDC) Number	Report Applicable (NDC) Number

Example 2: **[Drug X]**

HCPCS Level II Descriptor	**J1235** [Injection, **Drug X**, *250mL*
Unit of Measure (UM)	250mL is equal to 1 (UM) based on the HCPCS Level II code descriptor reported
Dose Administered (DA)	500mL
Correct Units Billed Calculation	Calculation: (DA [500mL] ÷ UM [250mL]) = 2 Units Billed
Incorrect Units Billed	500mL (Based on the reporting of the HCPCS Level II descriptor) which 1 (UM) equals 250mL **NOT** 500mL
NDC Number	Report Applicable (NDC) Number

Example 3: **[Drug Y]**

HCPCS Level II Descriptor	**J1236** [Injection, **Drug Y**, *1mg*
Unit of Measure (UM)	1mg is equal to 1 (UM) based on the HCPCS Level II code descriptor reported
Dose Administered (DA)	10mg
Correct Units Billed Calculation	Calculation: (DA [10mg] ÷ UM [1mg]) = 10 Units Billed
Incorrect Units Billed	10mg (Based on the reporting of the HCPCS Level II descriptor) which 1 (UM) equals 1mg **NOT** 10mg
NDC Number	Report Applicable (NDC) Number

Example 4: **[Drug XX]**

HCPCS Level II Descriptor	**J1237** [Injection, **Drug XX**, *up to 10mg*
Unit of Measure (UM)	The code descriptor covers 'up to 10mg' meaning any amount administered from 0.1 to 10 mg equals 1(UM) based on the HCPCS Level II code descriptor reported
Dose Administered (DA)	8mg
Correct Units Billed Calculation	Calculation: (DA [8mg] ÷ UM [up to 10 mg]) = 1 Unit Billed
Incorrect Units Billed	8mg (Based on the reporting of the HCPCS Level II descriptor) which 1 (UM) equals up to 10mg **NOT** 8mg
NDC Number	Report Applicable (NDC) Number

Example 5: **[Drug XY]**

HCPCS Level II Descriptor	**J1237** [Injection, **Drug XY**, *0.25mg*
Unit of Measure (UM)	0.25mg is equal to 1 (UM) based on the HCPCS Level II code descriptor reported
Dose Administered (DA)	0.75mg
Correct Units Billed Calculation	Calculation: (DA [0.75mg] ÷ UM [0.25 mg]) = 3 Unit Billed
Incorrect Units Billed	0.75mg (Based on the reporting of the HCPCS Level II descriptor) which 1 (UM) equals up to 0.25mg **NOT** 0.75mg
NDC Number	Report Applicable (NDC) Number

Drug Replacement(s)

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.

Drug Wastage

See Discarded Drugs and Biologicals (Professional and Facility)

Drugs New to Market

Optum Rx performs prior approval reviews for drugs new to market for both pharmacy and drugs administered in a physician's office. Below is an overview of the process:

- All drugs new to market **require prior approval**, unless notified otherwise. There is no notification of new drugs to market from Blue Cross VT or Optum Rx.
- Optum Rx prior approval request methods:
  - Web – CoverMyMeds
  - Fax – (844) 403-1029
  - Phone – (800) 313-7879
- Optum follows the new drugs to market criteria unless there are specific criteria available for the drug.
- The formulary will list new drugs to market as needing prior approval.
- Monthly, the list of drugs requiring prior approval will be updated to include any new drug to market
  - Note: Any drug that has been recently FDA approved requires prior approval. If you are unsure if the drug is a new drug to the market and/or do not see the drug listed as requiring prior approval, please call Optum Rx (866) 227-7849

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 Blue Cross VT 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.

Duplicate Services
See Payment Policy CPP_32 Claims Editing for details.

Durable Medical Equipment (DME)
See Section 11

Endoscopy (multiple)
See Payment Policy CPP_32 Claims Editing for details.

Evaluation and Management Services
See Payment Policy CPP_32 Claims Editing for details.
We have Coding Tip Sheets specific to E&M scenarios located on our provider website under Provider Forms & Resources, Coding Tip Sheets.

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
Blue Cross VT 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 Blue Cross VT 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.

NDC codes are not required for the flu vaccine, however, will be accepted if submitted. The NDC must be a valid, active code and reporting must be per our NDC guidelines (see Section 6.7 for details).

Frequency (Additional and Other Services)
See Payment Policy CPP_32 Claims Editing for details.

Frequency of Supplies (Diabetic and CPAP/BiPAP)
We have a payment policy for Frequency of Supplies (Diabetic and CPAP/BiPAP) (CPP_33). The policy outlines the frequency limits for diabetic, CPAP and BIPAP supplies. The policy is located on our provider website under Provider Policies, Provider Payment Policies.

See Payment Policy CPP_32 Claims Editing under "Continuous Positive Airway Pressure or Bilevel Positive Airway Pressure (CPAP/BIPAP) Frequency" for details.

G2211 - Office and Outpatient Evaluation and Management (E/M) Visit Complexity
We have a payment policy for G2211, Payment Policy CPP_39. The policy is located on our provider website under Provider Policies, Provider Payment Policies.

Global Services/Procedures/Surgery/Diagnostic and Radiology
See Payment Policy CPP_32 "Claims Editing" for details.

HCPCS Level II Drug Billing
See above "Drug HCPCS Level II Billing"

Habilitative Services
Some Blue Cross VT, 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 habilitative services do not have special billing requirements.

Hearing Aids and Related Services
Some Blue Cross and Blue Shield of Vermont members have benefits for hearing aids pursuant to the requirements set forth in 8 V.S.A. § 4088l see the details below. The State of Vermont Employer group, have specific billing instructions, see details below.

The information below is applicable to eligible Blue Cross and Blue Shield of Vermont and BlueCard members who have benefits for hearing aids (through the medical part of coverage), who are not

insured through the State of Vermont Employer Group:

Over the Counter (OTC) hearing aids are **NOT** eligible for benefits and cannot be billed to Blue Cross VT.

Network providers can render hearing exams and supply members with eligible hearing aid(s). If the practice does not supply hearing aids a script for the member to obtain the hearing aid(s) from a TruHearing® provider or another participating audiologist can be provided.

Our expectation is that a practice will have at least one hearing aid option for each eligible V code that is at or below our standard allowance.

If a member opts for a model that is above the standard option, informed consent (following the Waiver process defined in this handbook, in Section 6) will need to be obtained for the member to be financially responsible***** for the difference between our allowed amount and the billed charge. If an informed consent is not obtained and the member files a complaint with us, a practice will be expected to write off the difference between our allowance and the billed charge.

*****If an informed consent (waiver) is obtained for a BlueCard member, the related claim must be submitted on paper and include a copy of the signed informed consent (waiver). This will allow the claim to process reporting the correct member liability. If you do not submit with the initial claim submission, please contact your provider relations consultant for details on next steps.

State of Vermont Employer Group (prefix EVT and FVT) have hearing aid benefits available through their Blue Cross VT policies. Blue Cross VT contracted providers are eligible to render eligible services to these members. Claims are submitted to Blue Cross VT using the billing instructions below:

- Office visits and related services—follow national coding standards. Report a modifier -GY if applicable (see last bullet)
- Monoaural codes—must be billed with an appropriate modifier -LT or -RT and if applicable modifier -GY (see last bullet)
- Binaural codes—the only Blue Cross VT billing guideline is the reporting of a modifier -GY if applicable (see last bullet)
- If Medicare is the primary carrier, bill directly to Blue Cross VT. The service lines need to contain a modifier -GY, as these services are Medicare excluded, in addition to any other applicable modifier.

Home Births

We have a Payment Policy CPP_16 "Maternity Care and Home Births". The payment policy is located on our provider website under Provider Policies, Provider Payment Policies.

Home Infusion Therapy (HIT) Drug Services

We have a Payment Policy CPP_14 for HIT. The policy provides general information, eligible and ineligible services, billing guidance and reimbursements. Our payment policy for HIT is located on our provider website under Provider Policies, Provider Payment 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 CPP_05 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 provider website under Provider Policies, Provider Payment Policies.

Immunization Administration
See Section 6.7C for details

Implant Procedures (that require implant device)
See Payment Policy CPP_32 Claims Editing for 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 or 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 your statement covers the period from 030121 through 030321, then a revenue code line 0120 should report 2 units.

Inpatient Hospital – Services Incidental to Inpatient Admission (3 Day)
We have a Payment Policy CPP_54 for Services Incidental to Inpatient Admission. The policy is located on our provider website under Provider Policies, Provider Payment Policies.

Inpatient Hospital Room and Board, Routine Services, Supplies and Equipment
We have a Payment Policy CPP_08 for the Inpatient Hospital Room and Board, Routine Services, Supplies and Equipment.

The policy provides a description and benefit determinations plus billing guidelines and documentation. Our payment policy "Inpatient Hospital Room and Board, Routine Services, Supplies and Equipment" is located on our provider website under Provider Policies, Provider Payment Policies.

See also, Payment Policy CPP_32 Claims Editing under "Inpatient Only Services" for details.

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.

Lab 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/block 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/block number 17b or loop 2310A) is located within a contiguous county to Vermont and is contracted (either directly or through a group contract) with Blue Cross VT, the independent lab must bill Blue Cross VT directly.

For example: If the ordering provider is in Hanover, NH, contracted with Blue Cross VT through a group contract with Blue Cross VT and they sent a Blue Cross VT member's specimen to an independent clinical laboratory in Maine, the lab service must be billed to Blue Cross VT.

In order to ensure correct claim processing, the claim needs to be submitted to Blue Cross VT on paper and "Contiguous County" needs to be written on the top of the claim form.

Laboratory Handling
Use the appropriate 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 – Pass through Billing or Buy and Bill
This is when the laboratory who performs the service(s) bills the ordering providers office and the ordering providers office in turn bills Blue Cross VT. This type of billing is not allowed. Only in-network laboratories* should be used (unless a prior approval is secured), and the billing for the services are done directly by the in-network laboratory to Blue Cross VT.

*see Use of Non-Network Providers

Laboratory Services Self-Ordered by Patient
We require all laboratory services to 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:

- BlueCard members' benefits will be determined by the Blue Plan. Please be sure to verify benefits.
- For Federal Employee Program members, please contact the FEP customer service at (800) 328-0365 for details.

Lactation Services
See Payment Policy CPP_48 Lactation Services for details.

Lifetime Event
For services that can only be performed once or twice in a lifetime.
See Payment Policy CPP_32 Claims Editing 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 details.

Maternity Care and Home Births
We have a Payment Policy CPP_16 "Maternity Care and Home Births". The payment policy is located on our provider website under Provider Policies, Provider Payment Policies.

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 CPP_16 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 provider website under Provider Policies, Provider Payment Policies.

Also, see Payment Policy CPP_32 Claims Editing under "Obstetrics Package" for details.

Medical Nutrition Therapy and Nutritional Counseling
See Payment Policy CPP_53 Medical Nutrition Therapy and Nutritional Counseling for details.

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

See Payment Policy CPP_32 Claims Editing under "Maximum Units" or "Medicare Medically Unlikely Edits (MUE) Durable Medical Equipment" or "Medicare Medically Unlikely Edits (MUE) Outpatient Hospital DOS" or "Medicare Medically Unlikely Edits (MUE) Practitioner Date of Service" for details.

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

Medication Therapy Management (MTM) Pharmacy Services*:

Our Payment Policy CPP_35 for Medication Therapy Management (MTM) Pharmacy Services provides a description of the services, providers eligible to provide the services and billing guidelines. Our payment policy for Medication Therapy Management (MTM) Pharmacy Services is located on our provider website under Provider Policies, Provider Payment Policies.

*See Section 1.5 for information to enroll in the MTM program.

Mental Health or Substance Use Disorder Trainee

Our Payment Policy, "Supervised Practice of Mental Health/Substance Use Disorder Trainees CPP_37" provides the supervisor/trainee requirements and claim submission/coding requirements.

The policy is located on the provider website under Provider Policies, Provider Payment Policies.

Modifiers

See section 6.7B for details.

Multiple Codes

Claims containing two or more procedures used to report a service when a single, more comprehensive procedure code exists. See Payment Policy CPP_32 Claims Editing for details.

Multiple Evaluation and Management Services on the Same Day

See Payment Policy CPP_32 Claims Editing for details.

Multiple Procedures (including cardiovascular, endoscopic and ophthalmology)

See Payment Policy CPP_32 Claims Editing for 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 CPP_23 for "Never Events and Hospital Acquired Conditions" provides description, eligible and ineligible services, and billing guidelines. Our payment policy for "Never Events and Hospital Acquired Conditions" is located on our provider website under Provider Policies, Provider Payment Policies.

The "Never Events and Hospital Acquired Conditions" policy is administered retrospectively.

New Patient Code for Established Patients

See Payment Policy CPP_32 Claims Editing for details.

Newborn Billing

If the newborn does not have a name:

- Single birth—bill patient name as "Baby" with last name
- Multiple births—the first newborn (based on time of birth) is "BabyA" (no space between Baby and A) and last name, the second newborn (based on time of birth) is "BabyB" (no space between Baby and B) and last name and so on.

Claims should follow these naming guidelines to allow them to process to the correct membership and apply benefits accordingly.

If the newborn has a name on file or once a name is added to our membership, you can begin to bill under the patient's correct name.

Observation Services
We have a Payment Policy CPP_07 for Observation Services. The policy is located on our provider website under Provider Policies, Provider Payment Policies.

Occupational Therapy
Our Payment Policy CPP_38 "Outpatient Therapy Services (Occupational & Physical) Maximum Time Limit per Session" provides clarification to the corporate medical policy intent for therapy session maximum time limit. It is located on our provider website under Provider Policies, Provider Payment Policies.

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 with a modifier -CO. 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.

Office and Outpatient Evaluation and Management (E/M) Visit Complexity – G2211
We have a payment policy for G2211, Payment Policy CPP_39. The policy is located on our provider website under Provider Policies, Provider Payment Policies.

Operating and Recovery Room Services and Supplies
Our Payment Policy CPP_15 "Operating and Recovery Room Services and Supplies" provides a description, eligible and ineligible services and billing guidelines. It is located on our provider website under Provider Policies, Provider Payment Policies.

Ostomy Supplies
Our Payment Policy CPP_42 "Ostomy Supplies" provides a description, eligible services and billing guidelines. It is located on our provider website under Provider Policies, Provider Payment Policies.

Physical Therapy/Medicine
We have Coding Tip Sheets for Physical Medicine and Therapy with other services located on our provider website under Provider Forms & Resources under Coding Tip Sheets.

Our Payment Policy CPP_38 "Outpatient Therapy Services (Occupational & Physical) Maximum Time Limit per Session" provides clarification to the corporate medical policy intent for therapy session maximum time limit. It is located on our provider website under Provider Policies, Provider Payment Policies.

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 with a modifier -CQ. 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 (NPI).

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 places 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. Blue Cross VT has specific requirements that must be met for this place of service to be billed. Detailed information is in the Payment Policy CPP_12 "Urgent Care Clinics." The policy defines what an urgent care clinic is (free standing or hospital-based) and how the services should be billed. The policy is located on our provider website under Provider Policies, Provider Payment 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 Blue Cross VT 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).

Also see Payment Policy CPP_32 "Claims Editing" for details of edits related to place of service.

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 Provider Resource Center. Enter the surgical code being performed along with the evaluation and management code. Make sure you indicate on each service line the specific date it will or has been performed.

Also see, Payment Policy CPP_32 Claims Editing for details

Preventive Care
All preventive care is eligible for benefits, subject to medical necessity. However, some preventive care is not subject to member liabilities. Our Preventive Care Guide is located here: https://www.bluecrossvt.org/documents/preventive-care-guide and defines the services that do not have a member liability.

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

Primary Care Provider Waiver of Prior Authorization (Act 111)
See Section 12 for details on billing requirements

Provider Billing:

- **Provider Who Is Not Yet Enrolled/Credentialed Joining a Blue Cross VT-Contracted Provider Group**
  Providers joining a contracted provider group who are not yet enrolled/credentialed with Blue Cross VT are not eligible to provide services or bill for services for Blue Plan members until they are enrolled and approved by the Blue Cross VT credentialing committee, even if the member signs a waiver agreeing to financial responsibility. This reduces potential member confusion when a member receives care from a participating provider group. The approval date of the credentialing committee serves as the provider's effective date. 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. Please see "Claim Submission when Changing from Contracted to Non-Contracted and Vice Versa" in Section 6.1 for billing requirements.

- **Provider who is Enrolled/Credentialed through a different Group/Facility joining a New/Additional Blue Cross VT contracted Provider Group**
  Providers joining a new/additional contracted provider group who are already enrolled/credentialed with Blue Cross VT through a different group/facility are not eligible to provide services or bill for services for any Blue Plan members under the new group until they are enrolled and approved by the Blue Cross VT credentialing committee. Note: if the providers credentialing is in active status, an additional credentialing process is not required.

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

NDC codes are not required for the rabies vaccines, however, will be accepted if submitted. The NDC must be a valid, active code and reporting must be per our NDC guidelines (see Section 6.7 for details).

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).

See Payment Policy CPP_32 "Claims Editing" under "Professional, Technical and Global Services" for details.

Radiology Readings (Virtual)

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.

Blue Cross VT does not allow virtual radiology readings if the provider is located out of Country (including Canada). Do not submit claims for these services.

Radiology—Pay Percent

See Payment Policy CPP_32 "Claims Editing" under "Pay Percent Multiple Radiology" for details.

Readmission to a Facility

Our Payment Policy CPP_21 "Inpatient Hospital Readmission" provides description, eligible and ineligible services and billing guidelines. The policy as well as the process for filing a reconsideration for inpatient hospital readmission denial are located on our provider website under Provider Policies, Provider Payment Policies.

Revenue Codes
We follow the official UB 04 Data Specification Manual for definition, field attributes and notes with a few exceptions. Our exceptions are located on our website under Provider Forms & Resources, Claim Forms and Information – Outpatient Revenue Codes Requiring CPT® or HCPCS.

See Section 6.6 under "Claims Where Medicare Is Primary and a Reported Revenue Code does not have a HCPCS Code, however, Blue Cross VT requires a HCPCS Code."

See Payment Policy CPP_32 "Claims Editing" for details.

Robotic & Computer Assisted Surgery/Navigation
Our Payment Policy CPP_04 "Robotic & Computer Assisted Surgery/Navigation" is located on our provider website under Provider Policies, Provider Payment 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 Blue Cross VT 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/block number 17b
- Electronic—837 Loop 2310A

Spravato (esketamine)
See Payment Policy CPP_40 Spravato (esketamine) for details

State Supplied Vaccine/Toxoid
The State supplied vaccine/toxoids must be submitted for data reporting purposes. Use the appropriate 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 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 Blue Cross VT 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 lookback 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.

NDC codes are not required for the flu vaccine, however, will be accepted if submitted. The NDC must be a valid, active code and reporting must be per our NDC guidelines (see Section 6.7 for details).

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

Substance Use/Mental Health Disorder Trainee
Our Payment Policy "Supervised Practice of Mental Health and Substance Use Trainees CPP_37" provides the supervisor/trainee requirements and claim submission/coding requirements. It is located on our provider website under Provider Policies, Provider Payment Policies.

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.

Supervised Practice of Mental Health and Substance Use Trainees
See Payment Policy CPP_37 for details

Supplies
Submit using the appropriate CPT®/HCPCS code. Charges submitted with an unspecified code (99070) will be denied as non-covered for Blue Cross VT 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. If 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 Provider Resource Center.

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 Provider Resource Center. Enter in the services being performed along with the surgical tray code.

Telemedicine and Telephone
Our Payment Policies CPP_03 "Telemedicine" and CPP_24 "Telephone Only" defines eligible services and how the services need to be billed. These policies are located on our provider website under Provider Policies, Provider Payment Policies.

Notes:

- Telemedicine or telephone services are not eligible if the rendering provider is out of the country (this includes Canada). Claims cannot be submitted for consideration of benefits.
- A BlueCard® member's Blue Plan will determine the eligibility of telemedicine services.

Services provided via telemedicine that are not eligible per Attachment 1 of the payment policy; will process and deny as a provider liability. Members cannot be billed.

Therapy Pay Percent (facility):
See Payment Policy CPP_32 "Claims Editing" under "Pay Percent Therapy Facility" for details.

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

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

Travel (Provider's Expenses): see the waivers in Section 6 for details.

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

Unit Designations
Facility Billing – revenue codes are set up to allow multiple units, however, if the revenue code requires the reporting of a CPT®/HCPCS code, then the unit designation of the CPT®/HCPCS described below is applicable.

Each CPT®/HCPCS code has 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 once, on one claim line indicating one unit. If you indicate more than one unit, we will deny. *
    - 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 a corrected claim for any claims we deny for invalid units.

*Blue Cross VT 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 Blue Cross VT 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 how the program is administered.

A list of codes and their unit designations is available on our provider website under Provider Forms & Resources, Additional Resources.

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 documentation supporting the need for a change to the unit designation. 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:

Deadline to submit a request for review	Effective date if approved
November 15	January 1
February 15	April 1

May 15	July 1
August 1	October 1

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.

Unlisted Procedures, Services or Supply Codes
Providers should always bill a defined procedure, service or supply code when one is available. If a defined code is not available, services can be billed using the unlisted procedure, service or supply code (codes ending in "XXX99"). However, the claim must (1) be submitted on paper (until the time we are able to accept electronically) with (2) the office and/or operative notes (medical notes) and (3) include a written description of the service that was rendered and being billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes.

When a claim is received with a service line for an unlisted code, and the claim does not have both a written description of the service clearly visible and medical notes, the service line is denied as "*Plan Procedures Not Followed*" with a claim adjustment reason code of CO95. The provider is liable for this denial. This service cannot be billed to the member (even with a secured waiver) and cannot be appealed.

A provider can submit a request for review within a reasonable time, not to exceed 60 calendar days from the original date of processing with the CO95 denial reason. Review requests submitted beyond 60 days from the original processing with the CO95 denial will not be accepted.

To request a review, use one of the following methods:

- Email: utilizationmanagement@bcbsvt.com subject line: Unlisted Code Review or
- Fax: (866) 387-7914 Attn: Utilization Management; Unlisted Code Review

Note: if you are not able to email or fax and need to mail, please contact provider relations at (888) 449-0443 option 1 or providerrelations@bcbsvt.com to make arrangements.

Regardless of the method of submission, the request must include a (1) copy of the claim, with the (2) office and/or operative notes (medical notes) and include a (3) written description of the service that was rendered and billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes.

Notes:

- The resubmission must include ALL required information again, even if parts were previously submitted.
- If the review results in a denial and you are not in agreement with the decision rendered, the next step is to appeal. See details in Section 6 Member Liabilities *"Complaint and Grievance Process".*

Unlisted Procedures, Services or Supply Codes – Corrected Claims
The scenarios below cover the expectation of corrected claims that contract or will contain unlisted procedures, service or supply codes:

- **Corrected claim where original claim submission did not contain unlisted procedure(s), but the correction is adding unlisted procedure(s)** – Corrected claim must be on paper, meet the requirements of a corrected claim*, and include office and/or operative notes (medical notes) and a written description of the service that is billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes.
- **Corrected claim where the original claim submission had unlisted procedures and the correction is adding additional unlisted procedure(s)** – Corrected claim must be on paper, meet the requirements of a corrected claim*, and include office and/or operative notes (medical notes) and a written description of the added service(s) that is billed as an unlisted service. The written description must be clearly visible and not just part of the medical notes. It can be listed on the claim or written on the cover page/first page of the medical notes. The previously submitted and processed unlisted services will process exactly how they were previously processed (assuming the member still has coverage/benefits, etc.).

- **Corrected claim that changes something unrelated to an unlisted procedure that was previously processed -** These can be submitted electronically or on paper. The previously submitted and processed unlisted services will process exactly how they were previously processed (assuming the member still has coverage/benefits, etc.).

*See Section 6.1 under Adjustment/Corrected Claims for full details of how to submit a Paper Corrected Claim.

Urgent Care Clinic
Our Payment Policy CPP_12 "Urgent Care Clinics" defines what an urgent care clinic is (free standing or hospital-based) and how the services should be billed. It is located on our provider website under Provider Policies, Provider Payment Policies.

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

99499

If there are more than 12 diagnoses for a claim/service, submit a second claim using code 99499 and bill a $0 charge on (or $.01 if your system cannot support a zero charge) the additional claim. Include the additional diagnosis codes that went beyond the maximum codes allowed from original claim on this new claim.

- IMPORTANT: 99499 must be the only code on this claim.

If appropriate, submit remaining diagnoses using code 99499 with modifier 25 and bill a $0 on an additional claim.

Code 99499 will show as denied/rejected for payment on the 835/provider voucher; however, we will still capture the diagnosis codes affiliated with this procedure code.

Section 6.7A

Anesthesia

Anesthesia Code Edits: See Payment Policy CPP_32 "Claims Editing" for details.

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.

Blue Cross VT anesthesia codes are identified as codes 00100 thru 01999, 99100, 99116, 99135, 99140 and HCPCS codes D9222, D9223, D9224, D9225, D9239, D9243, D9244, D9245, D9246, & D9247

We use the American Society of Anesthesiologist (ASA) relative value guide for application of base value.

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

- If = or >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.

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

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

For anesthesia codes 01953, 01996, 99100, 99116, 99135, and 99140, time units are not a factor. Allowed amounts will be calculated using ASA base unit values (BUVs) multiplied by the anesthesia coefficient.

Example 01996 BUV = 3 multiplied by anesthesia coefficient $49.67—Allowed amount $149.01 (e.g., 3 X $49.67 = $149.01).

Modifiers

Blue Cross VT requires the use of the following anesthesia modifiers when applicable. Note: all but the Physical Status Modifiers (P1 – P6) must be billed in the first position of the modifier field):

Modifier	Description	Blue Cross VT Business Rules and/or Requirements
23	Unusual Anesthesia	Medical Director review of operative notes and/or office notes are required. Payment based on the clinical information provided.
47	Anesthesia by Surgeon	Informational—Modifier use will not impact reimbursement.
73	Surgical or diagnostic procedure was discontinued or terminated before planned anesthesia has been provided.	See Payment Policy CPP_22 “Modifier -52, -53, -73 -74” for requirements, billing and reimbursement.
74	Discounted Outpatient Procedure Prior to Anesthesia Administration	See Payment Policy CPP_22 “Modifier -52, -53, -73 -74” for requirements, billing and reimbursement.
AA	Anesthesia service performed personally by anesthesiologist	May impact reimbursement 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 modifier –AA and CRNA reports modifier -QZ.
AD	Medical supervision by a physician for more than four concurrent anesthesia procedures	50% of standard allowance
P1	A normal healthy patient	Informational—Modifier use will not impact reimbursement. This modifier is to be billed after all other modifiers are reported

P2	A patient with mild systemic disease	Informational—Modifier use will not impact reimbursement. This modifier is to be billed after all other modifiers are reported
P3	A patient with severe systemic disease	Informational—Modifier use will not impact reimbursement. This modifier is to be billed after all other modifiers are reported
P4	A patient with severe systemic disease that is a constant threat to life	Informational—Modifier use will not impact reimbursement. This modifier is to be billed after all other modifiers are reported
P5	A moribund patient who is not expected to survive without the operation	Informational—Modifier use will not impact reimbursement. This modifier is to be billed after all other modifiers are reported
P6	A declared brain-dead patient whose organs are being removed for donor purposes	Informational—Modifier use will not impact reimbursement. This modifier is to be billed after all other modifiers are reported
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Anesthesiologist submits a separate bill from a qualified individual. Allows 50% of standard allowance based on the appropriate unit rate
QS	Monitored anesthesia care services	Informational—Modifier use will not impact reimbursement.
QX	CRNA service: with medical direction by a physician	CRNA submits a separate bill from the anesthesiologist. Allows 50% of standard allowance based on the appropriate unit rate.
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.	Anesthesiologist submits a separate bill from the CRNA. Allows 50% of standard allowance based on the appropriate unit rate.
QZ	CRNA service, without medical direction by a physician	Allows 100% of standard allowance based on the appropriate unit rate.

Blue Cross VT 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.
6. Remain physically present and available for immediate diagnosis and treatment of emergencies.
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.

See modifier table above for Physical Status Modifiers and applicable business rules.

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/block 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 details of how to bill for anesthesia.

Anesthesia claims must be billed in minutes.

Below are the dental anesthesia services codes and how Blue Cross VT expects them to be billed:

HCPCS Code	Description
D9222	Administration of deep sedation/general anesthesia—first 15 minute increment, or any portion thereof
D9223	Administration of deep sedation/general anesthesia—each subsequent 15-minute increment, or any portion thereof
D9224	Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof
D9225	Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof
D9239	Administration of moderate sedation - intravenous - first 15 minute increment, or any portion thereof
D9243	Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof
D9244	In-office administration of minimal sedation - single drug-enteral
D9245	Administration of moderate sedation – enteral
D9246	Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof
D9247	Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof

Examples of how Blue Cross VT 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)
- Example 3: Administration of general anesthesia for 60 minutes (1 hour):

    - D9224—15 minutes (reported as 15 in 24g (paper billing) or MJ of 15 (electronic)
    - D9225—45 minutes (reported as 45 in 24g (paper billing) or MJ of 45 (electronic)
- Example 4: Administration of moderate sedation for 60 minutes (1 hour):
    - D9246—15 minutes (reported as 15 in 24g (paper billing) or MJ of 15 (electronic)
    - D9247—45 minutes (reported as 45 in 24g (paper billing) or MJ of 45 (electronic)

Base Value of Dental Anesthesia

D9223, D9225, D9243, D9244, D9245, & D9247 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, D9224, D9239, & D9246 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/block number 24g—(field titled "days or units") on the CMS 1500 claim form.

Notes:

- Not all BlueCard® members 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

See Payment Policy CPP_32 Claims Editing for details on the following:

- Anatomical Modifiers
- Assistant Surgeon Modifiers
- Clinical Trial Modifiers
- Co-Surgeon Modifier
- Global Services/Procedures/Surgery Modifiers
- Missing Professional Component Modifier -26
- Modifier to Procedure Validation Payment Modifiers
- Pay Percent for Assistant Surgery
- Pay Percent for Single Lines with Payment Modifier or Multiple Quantity
- Pay Percent Modifier -51
- Pay Percent Multiple Radiology
- Procedure Code Definition
- Separate Procedure
- Team Surgery
- Therapy and Assistant Therapy Modifier

We have Coding Tip Sheets specific to some modifiers located on our provider website under Provider Forms & Resources under Coding Tip Sheets.

The modifiers below have certain requirements for Blue Cross VT 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 must be reported. Claim lines containing more than one site-specific modifier are denied through the provider voucher. A corrected claim must 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 for payment. If a reduction has already been 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 define "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.

Modifier	Description	Blue Cross VT Allowance and/or Requirements
22	Increased Procedural Services	Blue Cross VT has a specific Payment Policy CPP_06 "Modifier -22) for this modifier. It is located on our provider website under Provider Policies, Provider Payment Policies. Blue Cross VT Payment Policy CPP_04 Robotic and Computer Assistive Devices provides details on expectation of usage for these services.
23	Unusual Anesthesia	See Section 6.7A for Details.
24	Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period	Informational—Modifier use will not impact reimbursement.
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.	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. We have Coding Tip Sheet specific to the use of modifier -25 located on our provider website under Provider Forms & Resources under Coding Tip Sheets.
26	Professional Component (Utilized when charge for the physician component is reported separately.)	Reimbursement based on fee schedule for professional component only.
32	Mandated Services	Informational—Modifier use will not impact reimbursement.
47	Anesthesia by Surgeon	See Section 6.7A for Details.
50	Bilateral Procedure	50% of standard allowance.

		For bilateral surgical procedures when there is no specific bilateral procedure code, use the appropriate 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.
51	Multiple Procedures	50% of standard allowance amount for surgical procedures
52	Reduced Services	Blue Cross VT has a specific Payment Policy CPP_22 "Modifier -52, -53, -73, -74" for this modifier. It is located on our provider website under Provider Policies, Provider Payment Policies.
53	Discontinued Procedure	See Payment Policy CPP_22 "Modifier -52, -53, -73 -74" for requirements, billing and reimbursement.
54	Surgical Care Only	85% of standard allowed amount for surgical procedure
55	Postoperative Management Only	10% of standard allowance amount for surgical procedure.
56	Preoperative Management Only	5% of standard allowed amount for surgical procedure.
57	Decision for Surgery	Blue Cross VT has a specific Payment Policy CPP_41 "Modifier -57 Decision for Surgery" for this modifier. It is located on our provider website under Provider Policies, Provider Payment Policies.
58	Staged or Related Procedure or Service by the Same Physician During the Postoperative Period	Informational—Modifier use will not impact reimbursement.
59	Distinct Procedural Service	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. There is a coding tip sheet related to modifier -59 posted to our provider website under Provider Forms & Resources, Coding Tip

		Sheets. The tip sheet includes directions on when to use a modifier -59 versus a modifier -XE, XS, XP or XU.
62	Two Surgeons	See Payment Policy CPP_50 Modifier -62 for requirements, billing and reimbursement.
63	Procedure Performed on Infants less than 4 kgs	Informational—Modifier use will not impact reimbursement
66	Surgical Team	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.
73	Surgical or diagnostic procedure was discontinued or terminated before planned anesthesia has been provided.	See Section 6.7A for Details.
74	Discounted Outpatient Procedure Prior to Anesthesia Administration	See Section 6.7A for Details.
76	Repeat Procedure by Same Physician	See Payment Policy CPP_51 “Modifiers -76, -77, -78, -79” for requirements, billing and reimbursement.
77	Repeat Procedure by Another Physician	See Payment Policy CPP_51 “Modifiers -76, -77, -78, -79” for requirements, billing and reimbursement.
78	Return to the Operating Room for a Related Procedure During the Postoperative Period.	See Payment Policy CPP_51 “Modifiers -76, -77, -78, -79” for requirements, billing and reimbursement.
79	Unrelated Procedure or Service by the Same Physician	See Payment Policy CPP_51 “Modifiers -76, -77, -78, -79” for requirements, billing and reimbursement.

	During the Postoperative Period	
80	Assistant Surgeon	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. 16% of standard allowed amount for primary surgical procedure.
81	Minimum Assistant Surgeon	We only allow when the surgical assist is present for a part of the surgical procedure. 16% of standard allowed amount for primary surgical procedure.
82	Assistant Surgeon (when qualified resident surgeon not available)	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. 16% of standard allowed amount for primary surgical procedure.
90	Reference (outside) Laboratory	Informational—Modifier use will not impact reimbursement. Modifier -90 can only be billed for referred laboratory services by an independent clinical laboratory. If the services are billed by a provider with a specialty other than laboratory or pathology with a modifier -90, the services may be denied.
91	Repeat Clinical Diagnostic Laboratory Test	Informational—Modifier use will not impact reimbursement.
96	Habilitative Services	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.
97	Rehabilitative	Informational—modifier will not impact reimbursement
99	Multiple Modifiers	Informational—Modifier use will not impact reimbursement.
AA	Anesthesia service performed personally by anesthesiologist	See Section 6.7A for Details.
AB	Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing	Informational—Modifier use will not impact reimbursement.

	assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary	
AD	Medical supervision by a physician for more than four concurrent anesthesia procedures	See Section 6.7A for Details.
AS	Physician's assistant, nurse practitioner or clinical nurse specialist services for assistant surgery.	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. 13.6% of standard allowed amount for primary surgical procedure
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply	Informational—Modifier use will not impact reimbursement.
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic	Informational—Modifier use will not impact reimbursement.
AW	Item furnished in conjunction with a surgical dressing	Informational—Modifier use will not impact reimbursement.
AX	Item furnished in conjunction with dialysis services	Informational—Modifier use will not impact reimbursement.
CG	Policy Criteria Applied	Informational – when allowed by a CMS based edit.
CO	Services deliver in whole or in part by an occupational therapy assistant	Details in our Corporate Medical Policy Occupational Therapy.
CQ	Services delivered in whole or in part by a physical therapy assistant	Details in our Corporate Medical Policy Physical Therapy/Medicine.
EY	No physician or other licensed health care provider ordered for this item or service	See Payment Policy CPP_33 "Frequency of Supplies (Diabetic and CPAP/BiPAP)" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.

FY	X-ray taken using computed radiography technology/cassette-based imagining	Informational—Modifier use will not impact reimbursement.
GC	This service has been performed in part by a resident under the direction of a teaching physician	Informational – Modifier use will not impact reimbursement. CANNOT be billed in the primary modifier position. The appropriate modifier needs to be billed in the first modifier position. Example – a resident assisting at surgery, modifier -80 or -81 should report in the primary modifier position with -GC in the second modifier position. Note: the modifier and services can only be billed by academic medical centers unless approval has been given by Blue Cross VT.
GO	Services delivered in an outpatient occupational therapy plan of care	Details in our Corporate Medical Policy Occupational Therapy.
GP	Services delivered under and outpatient physical therapy plan of care	Details in our Corporate Medical Policy Physical Therapy/Medicine.
GY	Item or service statutorily excluded does not meet the definition of any Medicare benefit for non-Medicare insurers, and is not a contracted benefit.	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 be used when submitting claims for Medicare members when the service or provider is statutorily excluded by Medicare*. NOTES: • Effective 1/1/24 the Centers for Medicare and Medicaid Services (CMS) began to recognize Licensed Marriage and Family Therapist and Licensed Clinical Mental Health Counselors as eligible providers. Providers with this type of licensure are NOT allowed to submit claims with dates of service 1/1/24 or after with a modifier -GY, unless they have opted out of Medicare (see next bullet) • Blue Cross VT allows providers who have opted out of Medicare to submit claim lines with a modifier -GY*. This removes the requirement of submitting each claim

		with a Medicare Opt out letter and will allow claim to process without an Explanation of Medicare Benefit. *This includes claims for FEP members. 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 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 Blue Cross VT. The submission of these claims to Blue Cross VT allows us to apply your contracted rate so the claims will accurately process according to the member's benefits. **BlueCard and Modifier -GY:** Medicare, through the COBA program, will automatically cross over claims for Medicare primary members to the members' Blue Plans for consideration of benefits. If a service line of a claim contains a modifier -GY, the member's Blue Plan will deny that service line (either through a letter or provider voucher) advising the claim must be submitted to the provider's contracted Blue Plan (Blue Cross VT). This is done so that we can apply the provider's contracted rate to eligible services. Services without a modifier -GY use Medicare's allowance; services with the modifier -GY use the provider's Blue Cross VT contracted rate. When submitting these claims for balances after Medicare to Blue Cross VT for a BlueCard member, include the original claim (with all lines, including those without the modifier -GY) and the Explanation of Medicare Benefits. Services that the member's Blue Plan has already processed will deny as duplicates and the lines with the modifier -GY will process according to the member's benefits. **FEP Claims**: Use of the modifier is required when applicable, see Section 9 FEP for more details. *NOTE: Blue Cross VT members with a supplemental plan (typically have a prefix of ZIB) do not have benefits available in the absence of Medicare coverage.

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 details. It is located on our provider website under Provider Policies, Provider Payment Policies.
HO	Master's degree level	Used when supervising trainee—see Payment Policy CPP_37 Supervised Practice of Mental Health and Substance Use Trainees for requirements, billing and reimbursement.
HP	Doctoral level	Informational—Modifier use will not impact reimbursement.
JA	Administered Intravenously	See Payment Policy CPP_47 "Discarded Drugs and Biologicals (Professional and Facility) for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
JB	Administered Subcutaneously	See Payment Policy CPP_47 "Discarded Drugs and Biologicals (Professional and Facility) for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
JG	Drug or biological acquired with 340b drug pricing program discount	Informational—Modifier use will not impact reimbursement.
JK	Drug supply 1 month or less	Informational—Modifier use will not impact reimbursement.
JL	Drug 3-month supply	Informational—Modifier use will not impact reimbursement.
JW	Drug amount discarded/not administered to any patient	See Payment Policy CPP_47 "Discarded Drugs and Biologicals (Professional and Facility) for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
JZ	Zero drug amount discarded/not administered to any patient	Informational—Modifier use will not impact reimbursement.
KS		See Payment Policy CPP_33 "Frequency of Supplies (Diabetic and CPAP/BiPAP)" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
KX		See Payment Policy CPP_33 Frequency of Supplies (Diabetic and CPAP/BiPAP for details. It is located on our provider website under Provider Policies, Provider Payment Policies.

LU	Fractionated payment of car-t therapy	Informational—Modifier use will not impact reimbursement.
N1	Group 1 oxygen coverage criteria met	Informational—Modifier use will not impact reimbursement.
N2	Group 2 oxygen coverage criteria met	Informational—Modifier use will not impact reimbursement.
N3	Group 3 oxygen coverage criteria met	Informational—Modifier use will not impact reimbursement
NU	New equipment	Informational—Modifier use will not impact reimbursement. See Payment Policy CPP_33 "Frequency of Supplies (Diabetic and CPAP/BiPAP)" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
P1	A normal healthy patient	See Section 6.7A for Details.
P2	A patient with mild systemic disease	See Section 6.7A for Details.
P3	A patient with severe systemic disease	See Section 6.7A for Details.
P4	A patient with severe systemic disease that is a constant threat to life	See Section 6.7A for Details.
P5	A moribund patient who is not expected to survive without the operation	See Section 6.7A for Details.
P6	A declared brain-dead patient whose organs are being removed for donor purposes	See Section 6.7A for Details.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	See Section 6.7A for Details.
QS	Monitored anesthesia care services	See Section 6.7A for Details.
QT	Recording and storage on tape by an analog tape recorder	Informational—Modifier use will not impact reimbursement.
QW	CLIA waived test	Informational—Modifier use will not impact reimbursement.

QX	CRNA service: with medical direction by a physician	See Section 6.7A for Details.
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.	See Section 6.7A for Details.
QZ	CRNA service, without medical direction by a physician	See Section 6.7A for Details.
RA	Replacement of a DME, orthotic or prosthetic item	Informational—Modifier use will not impact reimbursement. See Payment Policy CPP_33 "Frequency of Supplies (Diabetic and CPAP/BiPAP" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
RR	Rental (use RR modifier when DME is being rented)	Rental reimbursement applies when billed. See below for billing expectations. See Payment Policy CPP_33 "Frequency of Supplies (Diabetic and CPAP/BiPAP)" for details. It is located on our provider website under Provider Policies, Provider Payment Policies. See Payment Policy CPP_36 "DME Rental to Purchase Reimbursement" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
SH	Second concurrently administered infusion therapy	See Payment Policy CPP_14 "Home Infusion Therapy (Including Enteral Nutrition and Total Parenteral Nutrition" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
SJ	Third or more concurrently administered infusion therapy	See Payment Policy CPP_14 "Home Infusion Therapy (Including Enteral Nutrition and Total Parenteral Nutrition" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
SL	State-supplied vaccine	Allows $0.00. See detailed instructions below.
TB	Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes	Informational—Modifier use will not impact reimbursement.
TC	Technical component	Reimbursement based on fee schedule for technical component only.

TH	Obstetrical treatment/services, prenatal or postpartum	Informational – Modifier use will not impact reimbursement. See Payment Policies CPP_16 "Maternity Care and Home Birth" for details. It is located on our provider website under Provider Policies, Provider Payment Policies.
UE	Used Durable Medical Equipment	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 details. It is located on our provider website under Provider Policies, Provider Payment Policies.
X1	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	Informational—Modifier use will not impact reimbursement.
X2	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	Informational—Modifier use will not impact reimbursement.

	longitudinally but not providing general primary care services	
X3	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 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	Informational—Modifier use will not impact reimbursement.
X4	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	Informational—Modifier use will not impact reimbursement.
X5	Diagnostic services requested by another clinician: for reporting services by a clinician who furnishes care to	Informational—Modifier use will not impact reimbursement.

	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 interpretation of an imaging study requested by another clinician	

6.7C

Immunization Administration

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 (code 90460) and an add-on code (code 90461) when applicable.

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

Line	Code	Description	Unit Count
1	90649	Human papilloma virus vaccine quadriv 3 dose	1
2	90460	Immunization Administration through 18 yrs, any route 1st	1

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

Line	Code	Description	Unit Count
1	90710	Measles mumps rubella varicella vaccine live subq	1

	90460	Immunization Administration through 18 yrs, any route 1st vac/toxoid	1
3	90461	Immunization Administration through18 yrs, any route, ea. additional vaccine/toxoid	3

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

Line	Code	Description	Unit Count
1	90698	Dtap-hib-ipv vaccine im	1
2	90670	Pneumococcal conj vaccine 13 valent im	1
3	90680	Rotavirus vaccine pentavalent 3 dose live oral	1
4	90460	Immunization Administration through 18 yrs, any route 1st vaccine/toxoid	3
5	90461	Immunization Administration through 18 yrs, any route ea. additional vaccine/toxoid	4

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

When Blue Cross VT 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 lookback 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 an 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 40+ or younger women with risk factors can self-refer for mammogram screenings.

We have very specific coding requirements for screening mammograms and screening additional views ("screening callbacks") 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*:

CPT®/HCPCS Code	Primary ICD-10 Reporting
77063, 77067 (Append modifier -52 for unilateral exam)	N63.15, N63.25, R92.2, R92.8, Z00.00, Z00.01, Z12.31, Z12.39, Z80.3, Z85.3, Z86.000, Z86.018, Z86.03, Z90.10, Z90.11, Z90.12, Z90.13

For additional views or "call backs" if the initial screening mammography resulted in a BI-RADS 0 exam the following CPT ® & ICD 10-CM will be used and shall process at no member cost share. No modifier is necessary to indicate screening.

CPT®/HCPCS Code	Primary ICD-10 Reporting
19030, 76641, 76642, 77046, 77047, 77048, 77049, 77053, 77054, 77061, 77062, 77063, 77065, 77066, 77067, C8903, C8905, C8906, C8908, G0279 (Append modifier -52 to report a unilateral exam)	R92.2, R92.8, Z12.39, Z86.000, Z86.018, Z86.03

Please also note that the date of service may be same day or a subsequent date if there is an additional mammogram, ultrasound or other modality required to complete the screening examination.

While the national preventive care guidelines recommend screening mammography every one to two years, Blue Cross VT does not require that members wait at least 365 days between medically necessary, screening modality to access first-dollar coverage*.

*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 Trama** G9529—G9537
- **Miscellaneous Quality Measures** G9539—G9560
- **Opiate Therapy** G9561—G9579
- **Stroke Therapy** G9580– G9582
- **Opiate Therapy** G9583—G9585
- **Blunt Head Trama** 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

Eligible Services and Contracts

Blue Cross and Blue Shield of Vermont (Blue Cross VT) Policies

Medical Dental:

Blue Cross VT members have coverage for medical dental services as defined in our on-line Medical Policy "Dental Services for Accidental Injury, Gross Deformity, Head and Neck Cancers, and Congenital/Genetic Disorders". Located on this link: www.bluecrossvt.org/providers/provider-policies under the Vermont Medical Policies link.

Contract/Network Required	Blue Cross and Blue Shield of Vermont contract (888) 449-0443 option 2

Pediatric Dental for Non-Medical Conditions:

Blue Cross VT policies for Federally Qualified Health Plans have benefits available for pediatric dental if the members are aged 21 or under. The benefits are defined in our on-line Medical Policy "Dental Services Pediatric (Qualified Health Plans and Applicable Plans"). Located on this link: www.bluecrossvt.org/providers/provider-policies under the Vermont Medical Policies link.

NOTE: There are also some Administrative Services Only employer groups that have purchased dental coverage through Blue Cross VT that is administered by CBA Blue.

Contract/Network Required	CBA Blue (888) 222-9206 option 3 than 2 Email: CBADentalBlue@CBABlue.com

Note:

- CBA Blue responds to provider inquiries on dental services and claims related to the "Dental Services Pediatric", and Blue Cross VT responds to member inquiries related to "Dental Services for Accidental Injury, Gross Deformity, Head and Neck Cancers, and Congenital/Genetic Disorders". Pre-treatment or prior approval forms submitted to CBA Blue are responded to by CBA Blue using Blue Cross VT letterhead.
- If services incorporate both medical policies and prior approval is required, the prior approval needs to be submitted to Blue Cross VT. We will coordinate with CBA Blue for proper processing.

Claims can be sent to both, or if that is not possible, you may submit directly to Blue Cross VT and we will coordinate the processing.

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:

Contract/Network Required	Blue Cross and Blue Shield of Vermont contract (888) 449-0443 option 2

Federal Employee Program

FEP members with a Basic or Standard Options 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). For a copy of the MAC, please email providerrelations@bcbsvt.com.

Contract/Network Required	Blue Cross and Blue Shield of Vermont contract (888) 449-0443 option 2

Federal Employee Program – FEP BlueDental

FEP members can purchase a dental supplemental benefit, FEP BlueDental. Members who have purchased FEP BlueDental have a separate identification card. For these benefits:

Contract/Network Required	CBA Blue Phone: (888) 222-9206 option 3 then 2 Email: CBADentalBlue@CBABlue.com Uses Grid and Grid+ Network

Section 7

The BlueCard® Program

As a participating provider of Blue Cross VT, you must render services to patients who are national account members of other Blue Cross and/or Blue Shield Plans, and who travel to 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 to 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 Blue Cross VT and receive processing and/or payments directly.

Blue Cross VT 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 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.

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 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.
- 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 decisions through 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 Blue Cross VT online, real-time eligibility tool on our Provider Resource Center.
- 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 Blue Cross VT for processing. The provider voucher will inform you of member responsibilities.
- All services must be billed to the local Plan even if you've collected the member responsibility at the time of service This allows proper benefit determination updating of the member's claim

history. (Please review billing requirements as ancillary providers have separate billing instructions.)

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. Some Plans may have specific accreditation requirements for Mental Health and Substance Use facilities, beyond what Blue Cross VT requires for credentialing and contracting in order for benefits to be provided. 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 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

Blue Cross VT 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, 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.

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 Blue Cross VT Provider Resource Center
    - 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 Blue Cross VT* following the Blue Cross VT paper claim submission or the 837 companion guidelines. These are available on our Provider Resource Center. **Specific claim submission requirements for Blue Cross VT are provided in this handbook.**

- Paper claims:
    - Mail: BCBSVT, PO Box 186, Montpelier, VT 05601-0186
    - Email: claims@bcbsvt.com – please be advised, if you are emailing, the content of the email is not retained or reviewed
    - Fax: (866) 334-4232
- Electronic: Using a HIPAA-compliant 837 form to receive identification "BCBSVT."

*There are some circumstances in which claims may not be submitted to Blue Cross VT:

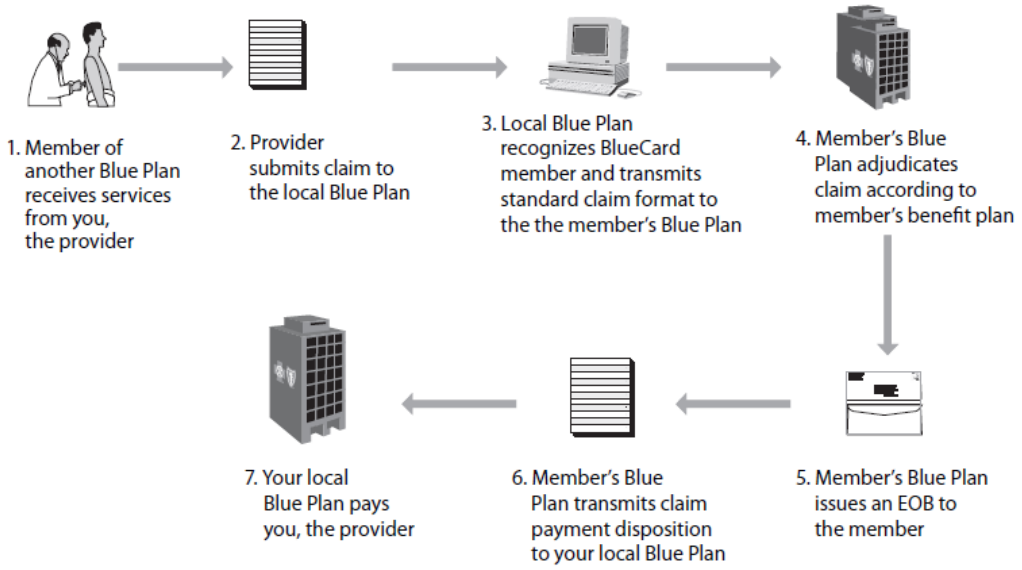
- Providers who render services in contiguous counties, contract with other Blue Plans, or have secondary locations outside the State of Vermont may not always submit directly to Blue Cross VT.

- There are three guides (Vermont and New Hampshire, Vermont and Massachusetts, Vermont and New York) located in Section 6.1 of this handbook to assist you in determining where to submit claims.

- 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 Blue Cross VT.
- Medicare adjusted claims must be submitted directly to the member's Blue Plan.
- Medicare Advantage or Vermont Blue Advantage paper claims.

Reminder: The member's complete identification number must include the three-character alpha prefix, which must bein capital letters. Claims with incorrect or missing alpha prefixes and/or incorrect 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 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.

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) slows down the claims payment process and creates confusion for the member as they will receive multiple EOBs.
- Do not send adjustments/corrected/late claims until you receive the original claim (or most recently submitted) processing on a provider voucher.
- Check claims status by contacting Blue Cross VT at (800) 395-3389 or using the online claim status tool on the Provider Resource Center.

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 to obtain covered services are out-of-network, usually at a higher cost share. 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 Blue Cross VT.
- 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 Blue Cross VT real-time eligibility search on the Provider Resource Center.
- Be sure to ask if MA benefits apply.
- If you have trouble obtaining eligibility information, please record the alpha prefix and report it to Blue Cross VT.

Medicare Advantage Claims Submission

Claims for non-Vermont Medicare Advantage are submitted using one of the following:

- Paper Claim—VBA, P O Box 260755, Plano, TX 75026
- Fax (800) 479-8973
- Electronic—submit to Blue Cross VT as you do for local members, using a plan code such as Blue Cross VT or SB915. We will direct the claim for processing.

Claim processing and if applicable, payment will be made directly by VBA.

Medicare Advantage Claim Inquiries

- Medicare Advantage claims are handled by Vermont Blue Advantage provider services team by phone at (844) 839-5122. Do not contact Blue Cross VT.

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 Blue Cross VT.
    - You must wait 30 days from the Medicare crossover date before submitting to Blue Cross VT.
  - 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 Blue Cross VT along with the Medicare remittance advice. You can make claim status inquiries for supplemental claims through Blue Cross VT.
- If you have any questions regarding the crossover indicator, please contact the Medicare intermediary.
- Do not submit Medicare-related claims to Blue Cross VT 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 Blue Cross VT.
- Do not send duplicate claims.
  - First, check a claim's status by contacting Blue Cross VT by phone (800) 395-3389 or through an online claim inquiry on the Provider Resource Center.

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.. These guides are in Section 6.1 of this handbook.

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 Blue Cross VT.

Medical Records

There are times when the member's Blue Plan will require medical records to review the claim. These requests will come from Blue Cross VT. Please forward all requested medical records with the request letter (it contains bar coding that assists in routing the medical records) to Blue Cross VT. We will coordinate with the members' 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 include 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 Blue Cross VT for BlueCard® claims. * They must be filed not more than 180 calendar days from the date of discharge (inpatient claims) or from the date of service (outpatient and professional claims), unless stated otherwise in provider contract. DO NOT submit adjusted/corrected/late claims until you receive the original (or most recently submitted) claim processing on a provider voucher.

*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.

Note: If you are changing a member's identification number and/or alpha prefix, do not submit as an adjusted/corrected claim. Submit as a new claim.

Complete details on how to submit adjusted/corrected claims are in Section 6.1 of this handbook.

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 will 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) which 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 Blue Cross VT. We coordinate the appeal process with the member's Blue Plan. There is a specific form for BlueCard® appeals on our provider website under Provider Forms & Resources, on the Claim Forms and Information link under BlueCard Appeal Form, that must be completed and sent with all BlueCard® appeals.

Reminders:

- A BlueCard appeal form should only be used when there is a confirmed denial of benefits
- Timely filing denials are not appealable and CANNOT be submitted on an appeal form.
    - If you would like timely filing reviewed – attach documentation supporting timely filing to a payment inquiry form and send by email to bluecard@bcbsvt.com
- Some Blue Plans may require members to sign an additional form specific to their Plan before they will start an appeal process.

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:

- Blue Cross VT or any other Blue Plan is the primary payer:
    - Submit the other carrier's name and address with the claim to Blue Cross VT.

    - 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 Blue Cross VT or any other Blue Plan is secondary:
    - Submit the claim to Blue Cross VT 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 nonpayment 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 does contact you and asks you to submit the claim to them, refer them to Blue Cross VT.

Section 8

The Blueprint Program

This section is under review and revision. If you have any questions, please email providerfiles@bcbsvt.com. Thank you.

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 Blue Cross VT, you must render services to FEP members who travel or live in Vermont. Blue Cross VT 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
- Whom 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. Blue Cross VT 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

Be sure to ask FEP members for a current membership identification card at every visit. 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 States logo

As a provider servicing out-of-area members, you may find the following tips helpful:

- Since new ID cards may be issued to members throughout the year, asking for current card at ever visit will ensure that you have the most up-to-date information file.
- Member IDs 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, Blue Cross VT 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:**

Plan Option	FEHB Enrollment Code		
	Self	**Self & Family**	**Self Plus One**
Standard Option (PPO)	104	105	106
Basic Option	111	112	113
FEP Blue Focus	131	132	133

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 Resource Center. Quick reference guides on how to submit transactions are posted to the eligibility link on the site.
- ***Phone:*** Call Federal Employee Program customer service at (800) 328-0365.

Advanced Benefit Determinations

FEP members are entitled to Blue Cross VT 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.

Advanced Benefit Determinations (ABD) should only be used for non-urgent services, procedures or medical equipment. Even if marked as urgent, they will follow the standard response timeframe.

Prior Approval

FEP members require prior approval for certain services, with eligibility based on medical necessity. There is a complete listing of services on our provider website under Prior Approval Authorization. The lists of services are updated annually in January. **Please note:** there are two separate prior approval lists for FEP members, one for members with 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 Blue Cross VT 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 Filing

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 Blue Cross VT).
3. Blue Cross VT recognizes FEP member and processes the claim according to member's benefit plan.
4. Blue Cross VT issues a Summary of Health Plan Payments to the member and a Provider Voucher to you.
5. You bill the member their cost share (member liability) as reported on the Provider Voucher.

To 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 on the Provider Resource Center or by calling (800) 328-0365. Be sure to provider the member's R alpha prefix.
- Submit all claims to Blue Cross Blue Shield of Vermont, 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/or 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 claim.
- Do not send duplicate claims. Sending another claim (or having your billing agency resubmit claims automatically) 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 may opt to purchase a dental supplement, FEP BlueDental (uses Grid and Grid+ network). Members who do so will have a separate identification card. It is important to request that the member supply both ID cards (FEP Blue Cross VT 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 Blue Cross VT. The FEP BlueDental network (for Vermont) consists of providers who have contracted through CBA Blue. **The Blue Cross and Blue Shield of Vermont (Blue Cross VT) 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 Blue Cross VT. 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.

FEP Member who becomes eligible for Medicare

When a FEP member becomes eligible for Medicare claims are priced using Medicare allowance, even if the member has not selected Medicare.

Claim details:

1) Claims must be submitted to Blue Cross VT following the Centers for Medicare and Medicaid Services (CMS) guidelines. Claims are priced at the Medicare allowance.
2) If a provider is not eligible for Medicare, claims must be submitted with a modifier -GY (see modifier section above for details on use of modifier -GY).
3) If you are Medicare eligible and opted out, you must bill with the modifier -GY.

FEP Members Without Medicare Part B

When an FEP member does not have Medicare Part B benefits, claims must be submitted to Blue Cross VT following the Centers for Medicare and Medicaid Services (CMS) guidelines. Claim will be priced at the Medicare allowances for the services.

FEP Members with Medicare as the Primary Payer

Some member liabilities are waived if original Medicare is the primary payer. Contact the FEP customer service team for more details.

FEP Members with Affordable Care Act Exchange or Marketplace Policies.

FEP does not coordinate benefits with these types of products. FEP is always primary regardless of whether the other plan makes a payment. Any coordination must be done with the other policy once FEP processes the claim.

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 on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides. If you have questions about electronic transaction requirements, please call Electronic Data Interchange (EDI) support at (800) 334-3441, option 2, or by email at ecommercesupport@bcbsvt.com.

General Electronic Data Interchange Remit Information: We provide electronic remits in an 835 HIPAA-compliant format. The 835's are available to providers/facilities for pick up. Some providers choose to use vendors/clearinghouses to receive and translate their 835's. A list of clearinghouses is available on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides.

HIPAA compliant 835 Electronic Remittance Advice (ERA)

835 files are placed on the Blue Cross VT secure SFTP site for pick up by the provider/vendor or clearinghouse.

Details regarding the 835 files are located in the 835 Companion Guide on our provider website under Provider Forms & Resources, Electronic Data Interchange Forms and Guides.

Other Blue Plan 835's

In addition to the 835 for Blue Cross VT members, we also post an 835 containing claim processing for members who have a Medicare supplemental policy or a Blue Cross and Blue Shield policy secondary to Medicare, for claims 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 crossover program that 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.
- Blue Cross VT 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 Blue Cross VT. Any questions related to the processing must be directed to the customer service number on the back of the member's 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.

Professional claims capitated services—New England Health Plan and Access Blue New England members' service lines that are processing as capitated will report a CO204 rather than the CO24. Providers need to identify and adjust the posting accordingly.

Facility and Professional claims – BlueCard claim issue only – issue is low volume and sporadic, claims receiving an internal claim reduction reason of 3 (provider are not able to see this) will report the claim with a claim status code of 01 (primary) rather than the correct 02 (secondary).

Facility and Professional claims – BlueCard claim issue only – A member's Blue Plan in the claim processing transaction to Blue Cross VT must report the member liability type (deductible, copay or coinsurance). If that detail is not supplied, the patient liability will report without an indicator.

Paper Provider Vouchers

A provider voucher is a document that reports 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. There is a FAQ regarding paper vouchers 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
  - Blue Cross VT 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.

- All vouchers for Blue Cross VT participating providers are posted to the Provider Resource Center in a PDF format. (If you receive payments via EFT, you must go to this location to review/print/download the voucher).
- Electronic payments are deposited on Fridays. If a federal banking holiday falls on a Friday, funds for that week are deposited on the following Monday.

Format of a Provider Voucher

- 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 Blue Cross VT 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 alerts the provider that this amount will be recovered on the next voucher.
    - 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 will 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 / Z083/".

          Note: Blue Cross VT-initiated adjustments without any change in processing do not report to 835's.

Sample voucher on next page.

BlueCross BlueShield of Vermont

FOR RELATED INQUIRES
PLEASE CALL OR WRITE:

BLUE CROSS BLUE SHIELD OF VERMONT
P.O BOX 186
MONTPELIER, VT 05601-0186

PROVIDER NUMBER	TAX ID
[redacted]	999999999
REFERENCE NUMBER	PAYMENT DATE
[redacted]	07/31/2018

PROVIDER VOUCHER

SERVICE DATES FROM/TO	PROCEDURE CODE CVD/NCVD	TOTAL CHARGES	ALLOWED AMOUNT	OTHER INSURANCE DOLLARS	PROVIDER'S LIABILITY	SUBSCRIBER'S LIABILITY	APPROVED TO PAY	AMOUNT PAID	RSN CODE
SUB ID: [redacted]			PATIENT: [redacted]						
CLAIM#: [redacted]			PATIENT ACCT/PRESCRIPTION#: [redacted]						
11/20/16		$5,500.00	$4,400.00	$0.00	$1,100.00	$0.00	$4,400.00	$5,194.25	A
11/26/16	006/000								
A-YOUR PAYMENT INCLUDES AN INTEREST PAYMENT OF $794.25 (Z010)									
SUBTOTALS:	006/000	$5,750.00	$4,650.00	$0.00	$1,100.00	$30.00	$4,620.00	$5,453.96	
TOTAL		$5,750.00	$4,650.00	$0.00	$1,100.00	$30.00	$4,620.00	$5,453.96	

PAGE 2 OF 2
[redacted]
004/915

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). Blue Cross VT does not utilize 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.
  - Blue Cross VT 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. Blue Cross VT is not utilizing the Prescription# field; however, the 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 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 Blue Cross VT system

Provider Voucher 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.

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.

Professional claims capitated services—New England Health Plan and Access Blue New England members service lines that are processed as capitated have variances from what you will see for a Blue Cross VT member who is capitated.

- In a situation where the service line is capitated and there is a member liability due, the member liability reports as the allowance for the service line and the provider write off will be the billed amount minus the member liability.
- In a situation where the service line is capitated and there is no member liability due, the allowed amount reports as zero and the entire billed charge reports as a provider write off.
- Regardless, capitated service lines report a CO24 rather than the CO204. Providers need to identify and adjust the posting accordingly.

Facility and Professional claims – BlueCard claim issue only – A member's Blue Plan in the claim processing transaction to Blue Cross VT must report the member liability type (deductible, copay or coinsurance). If that detail is not supplied, the patient liability will report in the patient liability field but will not have a remark code (such as $XX copay was applied).

Professional claims – BlueCard issue only – when a member has met their benefits limit, the reporting on the provider voucher does not reflect the member liable for the difference between the total charges and the allowed amount. The 835P does report correctly. You can bill the member for the full charged amount.

Facility and Professional claims - The Provider Voucher will not always report the negative claim adjusted if the original claim did not have any payments. The negative claim can be located in the 835 transaction. However, the adjusted claim will report to the Provider Voucher.

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 up" 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 should be reported. Paper claims should report a 1, and electronic claims (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: Why are BlueCard claims that have denied for lack of prior approval 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 on Wednesdays.
- 835's are available for pick up on Wednesdays

ClaimsXten-Select™ and Cotiviti. Inc., (coding software)—Addition of Lines

See section 6.4 for details on the ClaimsXten-Select™ and Cotiviti, Inc., coding 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 claim editing”.

Unit Limit Exceeded

If a claim is received with multiple units of service that exceed 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 two units and we only allow one, we will deny the claim line with the two units and add a pay line for one unit and a denied claim line for one unit. The 835 will reflect only the denied line for two units and the paid line for one unit.

Section 11

Durable Medical Equipment (DME) 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 when Blue Cross VT 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, Blue Cross VT 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 Blue Cross VT or the member for repair or replacement

DME "Upgrades"

DME suppliers are prohibited from billing Blue Cross VT for the standard/basic model and having the member pay the difference for upgraded DME supplies.

If a member elects to upgrade their DME supply to anything other than a standard/basic DME supply, Blue Cross VT considers the DME supply non-covered. The waiver process and requirements defined earlier in this handbook must be met and the member can be held liable for the entire cost of the DME supply.

DME Billing Guidelines

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 Blue Cross VT/NEHP/ABNE tracks ALL rental-to-purchase for all items. In addition, claims will require the bulleted items below.

- Rental-to-purchase:
    - See Payment Policy CPP_36 "DME Rental to Purchase" for details of how allowances are applied.
    - 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.
    - Rental only—Note: if a rental only code is billed as a purchase, the claim will be rejected on a provider voucher.
    - Rental-to-purchase.

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

DME Code Categorization – some DME supplies have a code categorization of:

- P = Purchase Only
- R = Rental Only
- T = Rental to Purchase

These categorizations can be located on our Unit Designation List, which is available on our provider website under Provider Forms and Resources and Additional Resources.

To request a review of DME code categorization, you must contact your provider relations consultant and provide the code along with any documentation supporting the need for a change to the code categorization. A committee will review the requests on a quarterly basis, and, if the committee deems a code categorization change appropriate, it will be effective as of the date of the next quarterly update. The chart below provides details on timing:

Deadline to submit a request for review	Effective date if approved
November 15	January 1
February 15	April 1
May 15	July 1

August 1	October 1

DME Rental to Purchase Reimbursement
See Payment Policy CPP_36 "DME Rental to Purchase Reimbursement" for details.

Frequency of Supplies (Diabetic and CPCP BIPAP)
See Payment Policy CPP_33 "Frequency of Supplies (Diabetic and CPAP BIPAP)" for details.

Medicare Medically Unlikely Edits (MUE) Durable Medical Equipment (DME)
See Payment Policy CPP_32 "Claims Editing" for details.

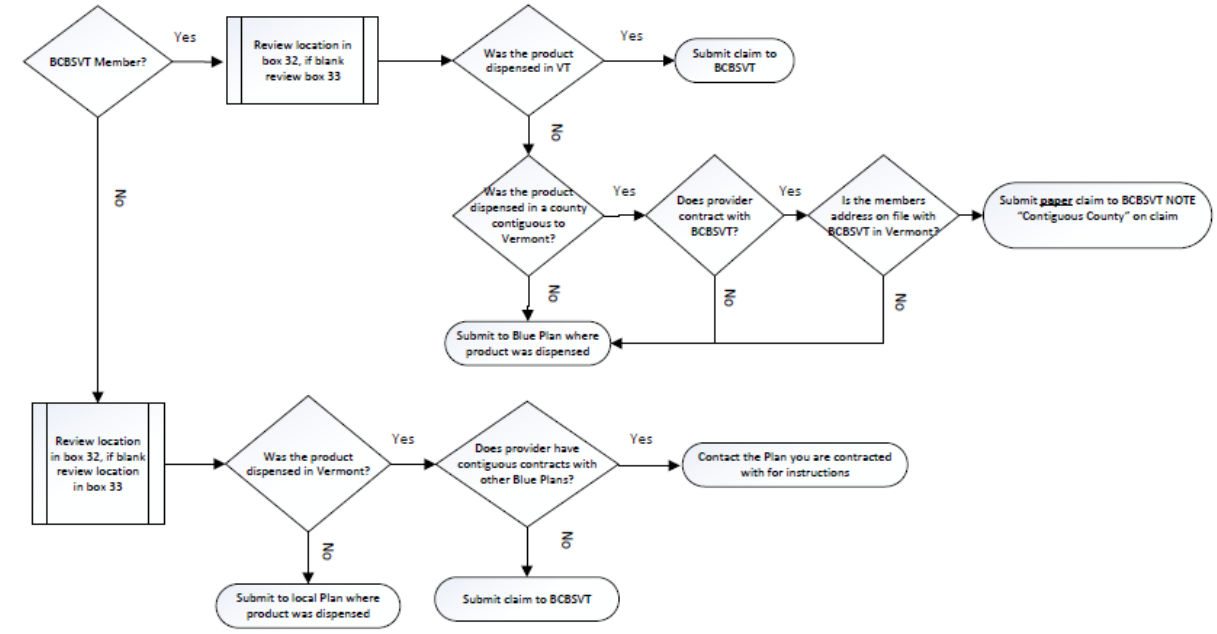
Claims submission guidelines for BlueCard®: Claims are to be submitted to the Plan in whose service area the equipment was shipped to or purchased at a retail store.

A complete claim submission flow chart is below. Note: When billed as a home place of service, the member's address determines the local Plan.

DURABLE MEDICAL EQUIPMENT CLAIM SUBMISSION FLOW CHART

<u>Place of Service 11</u> – Member Picked up Product at Provider Location
OR
<u>Place of Service 12</u> - Dispensed at Provider Location for use in home – submit paper claim and write at top of claim "Picked up in retail store"

(NOTE: This does not apply to the Federal Employee Program)



Section 12

Act 111 – Primary Care Provider waiver of Prior Authorization

Prior authorizations for medically necessary services (excluding prescription drugs or out of network services) are waived if a member is covered by a Vermont state regulated plan and the ordering provider meets the requirements below:

Provider Type **Set up in Blue Cross VT System**	**Provider Location (and when appropriate provider type)**	**Eligible for a Waiver**
Primary Care Provider (PCP)	Vermont	Yes, if there is a primary care contract with Blue Cross VT
Primary Care Provider (PCP)	Vermont and County Contiguous to Vermont	Yes, if there is a primary care contract with Blue Cross VT that covers the location(s).
Primary Care Provider	County Contiguous to Vermont	No
Dual Specialty Provider	Vermont - Specialist County Contiguous to Vermont – PCP	No, for any location(s)
Specialist	Vermont or County Contiguous to Vermont	No

Notes:

While the provider does not need to be in the Blue Cross VT member's selected primary care provider, the ordering provider must have engaged in clinical decision making for the ordered service.

Only in-network services are eligible for a prior authorization waiver. Out of network services and prescription drugs require prior authorization.

Member Requirements for Prior Authorization Waiver

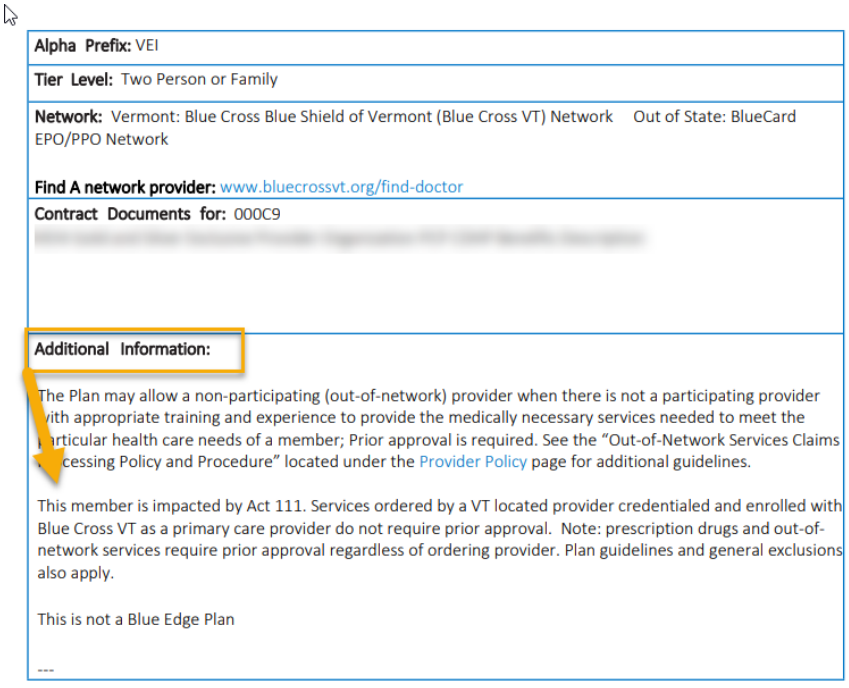
- The member is covered by a Vermont state regulated plan (meaning enrolled in a Qualified Health Plans, large group fully insured plan, New England Health Plan/Access Blue New England* or a governmental plan (State of Vermont, University of Vermont, and Vermont Education Health Initiative)). Members enrolled int the following plans are not eligible for prior authorization waiver: non-governmental, federal employee (prefix of "R"), BlueCard (other Blue Plans), Medicare Supplement, or Medicare Advantage.

*New England Health Plan/Access Blue New England members who have selected a Vermont primary care provider.

- You can identify eligible members by any of the following ways:
    - In a 27X transaction, a "YES" after the product name in the EB05 area means the member is eligible for prior authorization waiver (see image below).



    - The member's group number on their member ID card is listing in our online Act 111 Prior Authorization document. It is located on the provider forms and resources under the Additional Information – Employer group Number
    - Within the eQuote local eligibility area of the Provider Resource Center, there will be a call out in the additional information section (see image below)
        - **NOTE: the additional information field details will be updated to reflect the 1/1/26 change to eligible primary care providers. Updated example will be added once update is complete.**



1

Claims Submission Process

If you are the rendering and eligible ordering provider submitting a claim for a medically necessary qualifying service (ie., am imaging service, clinical laboratory, or durable medical equipment, prosthetics, orthotics and supplies) for a qualifying member, you must follow the below claim submission process for it to bypass the prior authorization requirements automatically.

If you are a rendering provider submitting a claim for an eligible ordering Vermont primary care provider as defined above for a qualifying service for a qualifying member, you must follow the below claim submission process for it to bypass the prior authorization requirements automatically.

CMS 1500 PAPER CLAIM FORM

Item/Block Number 17

Qualifier: DK ORDERING provider – enter to the left of the dotted vertical line

Name: enter first name, middle initial, last name and credentials to the right of the dotted vertical line

Example:

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

DK |Jane A. Smith MD

Item/Block Number 17b

Enter NPI to the left of the dotted vertical line and the NPI number of the ORDERING eligible Primary Care Provider to the right of the dotted vertical line

Example:

17b. | NPI | 0123456789

UB 04 PAPER CLAIM FORM

Form Locator 80 - REMARKS

Definition: Area: to capture additional information necessary to adjudicate the claim.

Populate line 1 with qualifier DK (ordering provider) immediately followed by the ordering provider's NPI number.

Example:

80 REMARKS

DK9876543210

ELECTRONIC 837P (professional) CLAIM SUBMISSION

Complete loop 2420E and use qualifier DK.

See the 837P companion guide on our provider website for more details, below is an overview

LOOP_ID-2420E_ORDERING_PROVIDER_NAME

NM1-Ordering_Provider_Name

NM1*DK*1*LASTNAME*FIRSTNAME***XX*ABC12345678900 ~

Highlight – areas that require population

ELECTRONIC 837I (institutional) CLAIM SUBMISSION

Use loop 2300, populate with a DK and Ordering provider NPI with no spaces, for example: DK9876543210. It will look like this in the 837I transaction NTE*UPI*DKXXXXXXXXXX (note the X's should be replaced by the ordering Primary Care Providers National Provider Identifier).

See the 837I companion guide on our provider website for more details, below is an overview

LOOP_ID-2300_CLAIM_INFORMATION

NTE-Claim_Note

NTE*UPI*DKXXXXXXXXX ~

Highlight – areas that require population

Claims Processing Questions for Prior Authorization Waivers

If your claim is denied and the qualifying service was ordered by an eligible Vermont primary care provider as defined above for a qualifying member, contact Customer Service for a claim review by phone (800) 924-3494 or emailing customerservice@bcbsvt.com.

Retrospective Review of Prior Approval

If a service is:

- denied for lack of prior approval and
- the rendering provider had believed the ordering provider and member qualified for a waiver of prior approval and
- the claim was submitted identifying the ordering provider and
- it has been 60 days or less since the denial of the claim

A retrospective prior approval request can be submitted. Please see Section 4 in this Provider Handbook under "Retrospective Review of Prior Approvals" for details.