Providers financially responsible for preapproval of inpatient facility services for out-of-area members
Understand provider responsibility for preapproval of inpatient facility services for out-of-area members

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Read about the importance of completing medical record requests from a Host Plan in a timely way

Claim requirements for Medicaid members
Learn more about the administration of Medicaid business as well as new requirements for providers coming in 2016

Use full member ID number when billing for service
Review the importance of using the full member ID number when billing for services rendered to Blue Plan members

Claim requirements for air ambulance service codes
As of April 19, 2015, claims from providers of emergency and non-emergency air ambulance services provided within the U.S., U.S. Virgin Islands, and Puerto Rico are to be filed to the local Plan in whose service area the point of pick-up occurred, per a new requirement from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. This change applies to the following service codes: A0430, A0431, A0435, A0436, S9960, S9961, and T2007.

Claims without a point of pick-up ZIP code, or claims with multiple ZIP codes, will be rejected.

Upon receiving the claim, the Host Plan must validate the point of pick-up ZIP code for air ambulance service on claims with dates of service on or after April 19, 2015. Validation is based on the following guidelines from the Centers for Medicare & Medicaid Services (CMS) for air ambulance claims:

• CMS-1500 (02/12) claim form or 837P. In item 23 of the CMS-1500 claim form, or the equivalent field of the 837 professional (loop 2420G), billers shall code the five-digit ZIP code of the point of pick-up. If the ZIP code is not in the Plan’s service area, the claim will be rejected.

• UB-04 claim form or 837I. When the UB-04 claim form is used for air ambulance service (excluding claims submitted with a facility’s negotiated arrangement with an air ambulance provider), billers shall populate Form Locators 39-41 with Value Code “A0” and the five-digit ZIP code of the point of pick-up (corresponding 837I field: Loop 2300, HI01-1 = BE, HI01-2 = A0, HI01-5 = Pick-up ZIP code). The Form Locator must be populated with the approved code and value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.

• Format. The format for a ZIP code is five digits. If a nine-digit ZIP code is submitted, the last four digits will be ignored. If the data submitted in the required field does not match that form, the claim will be rejected.

If you have any questions about this requirement, please contact Customer Service at 1-800-ASK-BLUE.
Providers financially responsible for preapproval of inpatient facility services for out-of-area members

Participating providers are financially responsible for obtaining preapproval for inpatient facility services for out-of-area members, and out-of-area members are held harmless for these services. While most providers currently obtain preapproval for inpatient facility services, this new requirement moved financial responsibility for lack of preapproval from the member to the provider.

Failure to obtain preapproval for inpatient facility services for out-of-area members will result in a denied claim. **To avoid claim denials, it is important to preapprove the inpatient stay and check that additional days are authorized before an out-of-area member is discharged.**

Providers must notify the member’s Home Plan of the following:

- within 48 hours, notify of any changes to the original pre-service review;
- within 72 hours, notify of any urgent/emergent inpatient admission.

Inpatient stay extensions for DRG/case rate facilities

In diagnosis related group (DRG)/case rate situations, when the length of an inpatient stay extends beyond the preapproved length of stay, any additional days should be approved by the last day of the originally approved days. For example, if five days are approved by the Home Plan and the patient has not been discharged by the fifth day, the provider should contact the Home Plan and ask to have the authorization updated. Please ensure that you seek approval of additional days to avoid payment issues.

Denied days within an approved inpatient stay for non-DRG/case rate facilities

In non-DRG/case rate situations, if there are denied days within an approved inpatient stay, the provider will be financially liable for the denied days and the member will be held harmless.

Get preapproval electronically

Independence offers Electronic Provider Access (EPA) through the NaviNet® web portal to access the provider portal of an out-of-area member’s Home Plan and conduct electronic pre-service reviews. Please note that providers may still need to call the member’s Home Plan to request preapproval if the Home Plan does not offer electronic pre-service review.

The PreService Review for Out of Area Members transaction is available under the Blue Exchange® Out of Area option in the Workflows menu. A user guide for this transaction is available in the NaviNet Resources section of our Provider News Center at [www.ibx.com/pnc](http://www.ibx.com/pnc). If you have any questions, call the eBusiness Hotline at 215-640-7410.

**Note:** Providers can also get preapproval for out-of-area members by calling the BlueCard Eligibility® line at 1-800-676-BLUE and asking to be transferred to the utilization review area.

Expediting medical record requests from the Host Plan

When a Host Plan receives a request for medical records from a Home Plan, it is very important that the records be sent in a timely manner to ensure that the claim is processed in a timely way and the services rendered to the out-of-area member are covered appropriately.

To expedite the handling for Host Plan medical record requests, please adhere to the following tips and guidelines:

- **Include a copy of the request letter with the medical records.**
- **Submit medical records by fax or email for the quickest processing.**
- **Only send the medical records that have been requested.**

**Note:** Independence cannot forward unsolicited medical records to another plan.

Host Plan medical records can be sent in the following ways:

- **Fax.** Securely fax medical records to 215-238-7915.
- **Email.** Email medical records to bluesquaredhostmedicalrecords@ibx.com.
- **Mail.** If you do not have access to fax or email, send medical records on a CD or in hardcopy to:
  
  Host Medical Records Department
  1901 Market Street
  SG1
  Philadelphia, PA 19103-1480

**Note:** This information does not apply to medical record requests directly from a Home Plan or to appeals.

**Reminder:** Appeals sent should clearly indicate the patient’s name, member ID number (including alpha prefix), and claim number, when applicable.
Claim requirements for Medicaid members

Blue Plans currently administer Medicaid programs in California, Delaware, Hawaii, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, and Wisconsin, providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each Blue Plan. Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases (e.g., continuity of care, children attending college out-of-state, lack of specialists in the member’s home state), a Medicaid member may receive care in another state, and generally that care requires prior authorization.

Identifying Medicaid members to determine eligibility and benefits

Blue Plan ID cards do not always indicate that a member has a Medicaid product. ID cards for Medicaid members do not include the suitcase logo that you see on most Blue Plan ID cards; however, they do include a disclaimer on the back of the ID card providing information about benefit limitations. For members with such ID cards, obtain eligibility and benefits information and preapproval for services as you would for other Blue out-of-area members:

- Use the NaviNet® web portal by selecting BlueExchange® Out of Area from the Workflows menu. To verify eligibility, use the Eligibility and Benefits Inquiry transaction.
- To request preapproval, use the PreService Review for Out of Area Members transaction.
- Call the BlueCard Eligibility® Line at 1-800-676-BLUE.

Medicaid reimbursement and billing

Claims for all Blue Plan Medicaid members should be submitted to your local Blue Plan (i.e., Independence). If you are contracted with Independence for Medicaid, your local Medicaid rates will only apply for Independence members; they would not apply to out-of-state Medicaid member claims. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member’s home state. Please note the following:

- Billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is specifically prohibited by Federal regulations (42 CFR 447.15).
- If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.
- In some circumstances, a state Medicaid program has an applicable copayment, deductible, or coinsurance applied to the member’s plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.
- When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

New claim requirements

Effective March 1, 2016, applicable Medicaid claims submitted without the National Drug Code, Rendering Provider Identifier (NPI), and Billing Provider Identifier (NPI) will be denied. Prior to March 1, 2016, applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.

In addition, applicable Medicaid claims submitted without the following data elements may also be pended or denied until the required information is received:

- billing provider (second) address line, middle name or initial, or taxonomy code;
- rendering provider taxonomy code;
- service laboratory/facility name, location information, state/province, and ZIP/postal code;
- ambulance transport information, distance, and reason code;
- value code and value code amount;
- condition code;
- occurrence codes and date;
- occurrence span codes and dates;
- referring provider identifier and identification code qualifier;
- ordering provider identifier and identification code qualifier;
- attending provider NPI;
- operating physician NPI;
- claim or line note text;
- certification condition applies indicator and condition indicator (Early and Periodic Screening Diagnosis and Treatment [EPSDT]);
- patient weight;
- round trip purpose description;
- stretcher purpose description.

Provider enrollment requirements

Some states require out-of-state providers to enroll in the state’s Medicaid program to be reimbursed. Some of these states may accept a provider’s Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state’s Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state’s Medicaid program before submitting the claim. If you submit
a claim without enrolling, your Medicaid claim will be denied and you will receive information from Independence regarding the Medicaid provider enrollment requirements. You will be required to enroll before the Medicaid claim can be processed and before you receive reimbursement.

**Commonly asked questions**

**How do I submit Medicaid claims?**

Medicaid claims should be submitted to your local Blue Plan in the same manner as you submit claims for other Blue out-of-area members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

**How do I know that I am seeing a Medicaid member?**

Members enrolled in a Blue Medicaid product are issued a Blue Plan ID card. Blue Plan Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. Blue Plan ID cards for Medicaid members:

- do not include a suitcase logo;
- contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness (for example, “This member has limited benefits outside of Pennsylvania.”).

Providers should always submit an eligibility inquiry if the Plan ID card has no suitcase logo and includes a disclaimer with benefit limitations using the BlueExchange transactions on NaviNet or the BlueCard Eligibility line. With an eligibility response, you should receive information on Medicaid coverage.

**What amount should I expect to receive for members who reside outside of Independence’s service area?**

When billing for services rendered to an out-of-state Blue Medicaid member, you will be reimbursed according to the member’s Home Plan Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service for local members.

**I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?**

Many state Medicaid programs require providers to enroll before reimbursement is provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

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**Use full member ID number when billing for service**

When billing for local and out-of-area claims, please remember to include both the alpha prefix and complete member ID number as it appears on the member’s ID card. Independence rejects claims not billed with the complete member ID number and date of birth.

For timely and accurate claim payment, the full member ID must be billed as it appears on the member ID card. Also, be sure that you are using the most recent ID card for the member.