Provider Manual

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INTRODUCTION

Blue Cross Blue Shield of North Dakota (BCBSND) recognizes that, at times, the administrative requirements of managing a patient's health care can be complex. The intent of this Provider Manual is to serve as a source for answers to some of the most common questions providers have about health plan coverage, claims filing procedures, policies and other facts related to administering care to BCBSND members.

This Provider Manual is not intended as a complete statement of all provider-related policies, procedures or standards of BCBSND. The Provider Manual outlines certain, but not all, policies and procedures adopted by BCBSND with respect to provider participation, claims filing and related subjects. Other policies and procedures, not reflected in this manual, are published regularly in HealthCare News, on the BCBSND website, in our member benefit certificates or health plans, or in other special publications, letters, or notices, including but not limited to credentialing standards, appeals policies and procedures, network terms and conditions, and provider contracts.

Disclaimer

This manual is provided for the convenience of BCBSND participating providers. BCBSND makes no representations or warranties with respect to the content of this manual. Neither this manual nor any statement in it constitutes a contract, policy, promise or obligation on the part of BCBSND. This is not a legally binding document. Any conflicting provisions in your Participation Agreement or in a member's benefit plan control over the conflicting provisions in this manual.

BCBSND reserves the right to revise this manual without obligation to notify any person of such revisions or changes. BCBSND further reserves the right to change any contract, policy, benefit plan or process referenced in this publication without updating this publication.

Updates to any part of this manual or to any policy or procedure referenced in this manual may be made by BCBSND at any time. BCBSND may give notice of such updates in a variety of ways, including but not limited to issuance of a letter to providers, publication in HealthCare News newsletter or other publications of BCBSND, or posting to the BCBSND website, www.BCBSND.com.

Nothing in this manual shall be interpreted as a guarantee of coverage of any service, treatment, drug or supply. Coverage or noncoverage is always governed exclusively by the terms of the member's benefit plan. Accordingly, in case of any question or doubt about coverage, providers should contact Provider Service at 800-368-2312 or 800-548-4026 for members of the Federal Employee Program (FEP).

Unless otherwise indicated, all references in this manual to "company" refer to Blue Cross Blue Shield of North Dakota.

Confidentiality of Member Information

In accordance with the highest standards of professionalism, and as a requirement of each provider's contract with BCBSND, providers are obligated to protect the personal health information of their BCBSND members from unauthorized or inappropriate use. All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements with BCBSND.

Compliance with the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2)

Providers that treat or diagnose patients for Substance Use Disorders (SUD) or refer patients for treatment of SUD are subject to the Confidentiality of Substance Use Disorder Patient Records Rule (42 C.F.R. Part 2) as a Part 2 Program. Part 2 is intended to protect patients who are receiving treatment for a SUD from adverse consequences of the disclosure of their records. Blue Cross Blue Shield of North Dakota (BCBSND) payment of any claim submitted for such services is contingent upon compliance with the following requirements:

- Obtain appropriate consent: Valid Provider consent form
    - Provider is prohibited by law from disclosing PII to BCBSND without obtaining patient's consent. BCBSND is prohibited by law from using PII to pay any claim (or to process any other information) in the absence of such consent. Accordingly, by submitting any claim (or other record) that contains PII to BCBSND, Provider represents and warrants that Provider has first obtained patient consent in substantially the same form as the BCBSND PII Consent Form example, which is available within this Provider Manual. BCBSND reserves the right to deny payment of claims (and the right to refuse to process other information) in the event that Provider fails to obtain such consent.
- Provide the Part 2 Disclaimer:
  "42 CFR part 2 prohibits unauthorized disclosure of these records."
    - Provider is prohibited by law from disclosing PII to BCBSND pursuant to patient's consent, unless it includes with the PII a specific statement to notify BCBSND that the information is subject to Substance Use Disorder confidentiality restrictions ("Part 2 Disclaimer"). Accordingly, Provider shall include the Part 2 Disclaimer with any claim (or other record) that contains PII when submitting the claim (or other record) to BCBSND. Provider shall include Part 2 Disclaimer with claims it submits to BCBSND in the following manner:
- 837 Professional Claims:
    - Electronic: Should use the NTE data segment Loop 2300 to provide the Part 2 Disclaimer. Data element NTE01 should use the qualifier "ADD." Data element NTE02 should contain the Part 2 Disclaimer.

Paper: Should include the Part 2 Disclaimer in Field 19; the Disclaimer should be preceded by the qualifier “ADD.”

- 837 Institutional Claims:
  - Electronic: Should use the NTE data segment in Loop 2300 to provide the Part 2 Disclaimer. Data element NTE01 should use the qualifier “ADD.” Data element NTE02 should contain the Part 2 Disclaimer.
    Paper: Should include the Part 2 Disclaimer in Field 80 (no qualifier is necessary).
- Provide PII to BCBSND, upon request and as deemed reasonably necessary by BCBSND, to perform evaluations, audits or research.

Definitions of the capitalized terms “Part 2 Program”, “Patient Identifying Information” and “Substance Use Disorder” are consistent with the meanings provided in 42 C.F.R. § 2.11.

ACCREDITATION

BCBSND holds full Utilization Review Accreditation Commission (URAC) accreditation for Health Plan and Health Plan with Health Insurance Marketplace. URAC is an independent, nonprofit health care accrediting organization promoting health care quality through accreditation, education and measurement. URAC reviews a company’s operations to ensure that the company is conducting business in a manner consistent with national standards. URAC accredits many types of health care organizations
for different programs, such as Health Plan Accreditation, which reviews the entire organization’s health plan standards. The standards are grouped into modules, with several modules and many standards guiding policy development in the following areas of importance to provider networks:

- Network management
- Credentialing
- Quality Management, including quality measures reporting requirements
- Health Utilization Management

For additional information about URAC, visit www.urac.org.

COMMUNICATING WITH BCBSND

BlueCard Eligibility Line

Benefit information on BlueCard is available by calling the BlueCard Eligibility Line at 800-676-BLUE (2583).

For Availity Essentials Technical Assistance Questions:

- Contact Client Services at 800-282-4548
- Monday through Friday, 7 a.m. to 7 p.m. CST

Member Services

If patients have questions about their health care benefits, providers should tell them to call the number on the back of their ID card. If they don't have their card, refer them to Member Services at 844-363-8457.

BCBSND Provider Service

Toll Free: 800-368-2312
Local: 701-282-1090

Mail:
ATTN: Provider Service
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121

Hours:
- 8 a.m. to 4:30 p.m. CST Monday, Tuesday, Thursday, Friday
- 10 a.m. to 4:30 p.m. CST Wednesday

Use NPI When Calling BCBSND Provider Service

To comply with HIPAA privacy rules and regulations, Provider Service must verify the identity and authority of each provider contacting Provider Service. Be prepared to give the following information when calling Provider Service:

- Caller's name
- Rendering provider's NPI number
- Provider name
- Telephone number
- Patient's Benefit Plan Number (BPN)
- Patient's name
- Date of service
- Type of service being provided

Provider Service cannot accept any other types of information for verification in place of the required items listed above. Please be prepared to give the rendering provider's NPI number when you call Provider Service. If the NPI number is not available at the time of the call, information cannot be released.

FEDERAL EMPLOYEE PROGRAM (FEP)

Toll Free: 800-548-4026
Local: 701-282-1468
Hours: 8 a.m. to 4:30 p.m. CST

Member Precertifications

Selected services require precertification (see the Care Coordination section of this manual for a listing of those services). A listing of services requiring precertification can be found on our website under Policies & Approvals. Precertification requests are submitted through the Availity Essentials portal.

Utilization Management

Toll Free: 800-952-8462
Fax: 701-277-2253

Mail:
ATTN: Medical Management
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121
Hours: 8 a.m. to 5 p.m. CST

Case Management

Toll Free: 800-336-2488

Mail:
ATTN: Case Management
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121
Hours: 8 a.m. to 5 p.m. CST

Managed Benefits & Medical Management

- Inpatient Medical/Surgical Hospital Admissions, nonparticipating providers, home health, hospice, skilled nursing facility, transitional care unit, swing bed, acute rehab and long-term acute care (this includes precertifications, admission notification and concurrent review). This also includes Inpatient Psychiatric and Substance Abuse Admissions and Ambulatory Behavioral Healthcare (partial hospitalization, residential treatment center).

  Toll Free: 800-952-8462
  Fax: 701-277-2253
  Hours: 8 a.m. to 5 p.m. CST

- Case Management

  Toll Free: 800-336-2488
  Local: 701-277-2100
  Fax: 1-701-282-1967
  Hours: 8 a.m. to 5 p.m. CST

Credentialing & Provider Data Management

Credentialing/Recredentialing/Provider Directory Changes

Toll Free: 800-756-2749
Fax: 701-282-1910

Mail:
ATTN: Credentialing & Provider Data Management
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121

Email: prov.net@bcbsnd.com

For directory changes, visit: www.BCBSND.com/web/providers/forms.

Provider Relations Services

Provider Relations Partners and Provider Education Specialists assist providers and their office staff with complex claim situations and provide information about BCBSND's programs. For questions regarding the contents of this manual, please contact prov.partners@bcbsnd.com. Please do not contact the Provider Relations Partners with routine claim or benefit questions.

HealthCare News
BCBSND produces HealthCare Newsletter on a bi-monthly basis to communicate important policy and benefit-related news to providers. Also included are helpful tips and reminders on how to file claims and conduct other business more efficiently with BCBSND. This online publication is emailed to BCBSND participating providers who have registered for provider news.

Provider News Blasts

To receive e-mail notification of HealthCare News, medical policy, coding and billing information, processing issues, system outage notifications and other important announcements from BCBSND, subscribe to Provider News.

1. Go to www.BCBSND.com/providers, click on "Provider Services" and then "News & Resources"
2. Click "Subscribe to Provider News Email Updates"
3. Upon submission, you will receive a confirmation on screen that you have successfully subscribed
4. If you do not receive your confirmation email or new article publications, check your spam folder. If nothing appears in your spam folder, contact the Customer Contact Center Provider Service department for troubleshooting assistance.

PROVIDER PARTICIPATION

Participating providers are those physicians, allied health providers and facilities that have entered into a Provider Group Participation Agreement with BCBSND. As a participating provider, you join other providers linked together through a relationship with BCBSND.

To acknowledge the increasing diversity in your patients, our members, BCBSND expects participating providers to develop and conduct cultural competence training for all practitioners and employees. This training should include, at a minimum, annual reminders that capture the following information:

- Compliance with Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000, et seq, which prohibits discrimination on the basis of race, color, and national origin in programs that receive federal financial assistance
- Compliance in assisting members with accessing language services (providers may contact BCBSND for assistance)
- Compliance in providing services in a culturally sensitive manner

Provider Group Participation Agreements

Your responsibilities as a participating provider are defined in your provider participation agreement(s). You should always refer to your agreement when you have a question about your participation. As a participating provider, you also have the following responsibilities to our members—your patients.

Network Exhibits

The Provider Group Participation Agreement contains exhibits for various health products, including FEP and Preferred Blue PPO (BlueCard). The exhibits are used to determine network benefits in the event a member's product has benefit differentials within the benefit plan. BCBSND requires providers to sign the base Provider Group Participation Agreement prior to selecting specific networks. The base agreement requires providers to accept reimbursement for services provided under the terms of the member's benefit plan. Even though a provider may not sign a network exhibit, it does not preclude them from their roles and responsibilities within the Provider Group Participation Agreement.

Submitting claims for BCBSND members

This includes claims for inpatient, outpatient, ancillary and office services. To ensure prompt and accurate payment, it is important that you provide all patient information on the appropriate claim form (837P, 837I, CMS-1500 or UB-04) This includes appropriate Physicians' Current Procedural Terminology (CPT®) codes and ICD-10-CM diagnosis codes. National Provider Identifiers (NPIs) are required on all claims. The Claims Submission section of this manual gives specific information about completing the claim form as well as CPT and ICD-10-CM coding information.

Accepting BCBSND's payment plus the member's deductible, coinsurance and/or copayment, if applicable, as payment in full for covered services

BCBSND's payment for covered services is based on the lesser of the participating provider's charge or BCBSND's allowed amount. You may bill the member for any deductible, coinsurance, copayment or non-covered service as determined by BCBSND. However, you agree not to collect from the member any amount over BCBSND's allowed amount.

The provider remittance advice summarizes each claim and itemizes patient liability, the amount above the allowed amount and other payment information.

Modifications to Provider Agreements and Fee Schedules

BCBSND shall notify participating providers at least 30 days prior to the effective date of any material modification of BCBSND's participation agreements. In addition, BCBSND shall notify participating providers 60 days prior to the effective date of the annual fee schedule changes for Health Care Institutions and 30 days prior to the effective date of the annual changes for Health Care Professionals.

Member Discrimination

Providers shall not discriminate against any member on the basis of their BCBSND membership, source of benefit payment, gender, age, race, color, religion, origin, health status or disability in providing covered services under any BCBSND participation agreement.

Provider Member Communications

Regardless of any benefit or coverage exclusions or limitations associated with a Benefit Plan, Provider shall not be prohibited from discussing fully with Members any issues related to Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by BCBSND or any other party.

Provider Dispute Resolution Process

Provider Partnerships staff track all written and verbal disputes from participating providers. For purposes of this policy, a dispute is defined as a written or verbal complaint regarding administrative matters, including:

- Claims payment, handling or reimbursement for health care services such as disputes regarding modifiers, reduction of the intensity of Evaluation and Management codes or other service codes, bundling logic or claim adjustments, etc.
- Matters pertaining to the contractual relationship between a provider and the health plan.
- Medical policies, internal processes and other matters

The provider has the right to consideration by an authorized representative of the organization not involved in the initial decision that is the subject of the dispute. Please contact prov.partners@bcbsnd.com with any questions, concerns or complaints.

Nonparticipating Providers

Nonparticipating providers do not have a contract with BCBSND. We use an allowed amount to determine what to pay for a member's covered services when a member receives care from a nonparticipating provider. The member will receive a lower level of benefit because they did not receive care from a participating provider. The member is responsible for any charges exceeding of the allowance for covered services.

If a member receives covered services from a nonparticipating provider, the member will be responsible for notifying BCBSND of the receipt of services. If BCBSND needs copies of medical records to process the member's claim, the member is responsible for obtaining such records from the nonparticipating provider. In addition, the member will be responsible for compliance with all required managed benefits provisions.

Members usually pay significant costs when using nonparticipating providers. This is because the amounts that providers charge for covered services are usually higher than the fees that are accepted by participating providers. In addition, participating providers waive the difference between the actual billed charge for covered services and the allowed amount, while nonparticipating providers do not. The nonparticipating provider may balance bill the member for all amounts not paid by BCBSND.

Note: The member's policy is an agreement between the member and BCBSND only. Providers cannot waive the member's cost sharing obligations.

Credentialing Program

Participating providers are expected to comply with BCBSND's policies and procedures, including credentialing and recredentialing. For up-to-date information regarding BCBSND's credentialing program, please refer to the Credentialing and Recredentialing Policy found on https://www.bcbsnd.com/providers/credentialing/credentialing-applications.

The Credentialing Committee, which includes BCBSND medical directors and participating providers in the community, establishes, reviews and approves the policies, standards for participation, procedures and processes that govern credentialing operations. This committee makes all final determinations regarding approval or denial of credentialing and recredentialing applications.

Provider Participation Status

Providers may be classified by BCBSND as:

Participating:

- The provider has a legal agreement with BCBSND to provide covered services to members
- Payments are made to the provider, unless otherwise specified

Non-participating:

- The eligible provider does not have a legal agreement with BCBSND, has elected not to participate with BCBSND or has been terminated
- Providers that voluntarily terminate participation with BCBSND shall be terminated 60 days from the notice of termination. Providers that voluntarily terminate participation will be ineligible for participation again with BCBSND for a period of one year
- Providers denied continued participation due to non-compliance with credentialing requirements shall be changed to nonparticipating or non-payable 60 days from the date of the Credentialing Committee decision. Denied providers may reapply for participation 18 months after the denial (See the Credentialing and Recredentialing Policy for denial and appeals information)
- Payments are made to the member and the provider may collect directly from the member

Non-payable:

- The provider does not meet licensing or certification criteria per credentialing guidelines stated in Credentialing and Recredentialing Policy
- The provider is licensed or certified as a provider type BCBSND does not recognize as payable
- The provider is designated non-payable as a result of a Corrective Action Plan
- Services provided are non-reimbursable and are the liability of the member

A provider is required to report any disciplinary actions or changes to license or malpractice status within 15 days of the occurrence according to the terms indicated in the Provider Group Participation Agreement. Failure to do so may affect participation.

Credentialing and Recredentialing Process

Credentialing consists of a complete review of a provider's credentials at the time of application to BCBSND. A credentialing application is completed by the provider and submitted to BCBSND for approval.

Note: Each organization must have a signed Provider Group Participation Agreement on file before credentialing can be completed.

- Upon receipt of the completed application, credentialing staff verify the provider's credentials, including state license, professional malpractice, liability insurance, etc., according to the BCBSND's Credentialing and Recredentialing Policy, as well as the URAC accreditation standards
- Based on compliance with the criteria, BCBSND staff will recommend to the Credentialing Committee that a provider credentialing be approved or denied. The committee then makes its determination

After a provider has completed the initial credentialing process, they will undergo recredentialing at least every three years thereafter from the date of the last approval. The recredentialing process is conducted in the same manner as outlined in the Credentialing section above.

The provider is considered to be approved by the Credentialing Committee and recredentialed for a three-year cycle unless otherwise notified.

Tips to Avoid Delays

BCBSND recommends providers begin filling out credentialing paperwork when they are hired instead of the day they start working.

Commonly missed credentialing items that cause delays:

- Malpractice or liability certificate of insurance:
  - Provider's name must be listed on certificate of insurance.
  - Attach a roster or letter listing insured provider(s).
- Missing information that will cause application to be returned:
  - Yes or No questions regarding health status, criminal history, and license or malpractice history. All must be answered, and "Yes" responses explained.
  - Signature and signature date.

While You Wait

Providers are strongly encouraged not to see BCBSND members until credentialing is approved.

If you do see members while the credentialing application is in process, do not submit claims to BCBSND until you receive a letter indicating that your application has processed. If a claim is filed prior to being approved, the provider is responsible to refile the claim.

Provider Availability Standards

BCBSND is committed to providing high-quality health care to all members, promoting healthier lifestyles and ensuring member satisfaction with the delivery of care. BCBSND has established standards to ensure that all covered services, including additional or supplemental services contracted for or on behalf of the member, are available and accessible 24 hours a day, seven days a week, when medically necessary.

Access and Availability Standards

BCBSND's standards are designed to ensure that all covered services provided by primary care and specialty care providers, including additional or supplemental services contracted for or on behalf of the member, are available and accessible 24 hours a day, seven days a week, when medically necessary.

BCBSND will ensure that provider after-hours answering machines instruct members to go to an emergency room or call 911, in the event of an emergency.

Appointment Availability and Access Standards

Primary Care Providers:

- Within 21 calendar days for routine, non-urgent appointments
- Within 60 calendar days for school physicals
- Within 2 calendar days for urgent, symptomatic, but not life-threatening care (care that can be treated in the doctor's office)
- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Obstetrics and Gynecology (OBGYN) providers:

- Within 30 calendar days for routine, non-urgent appointments
- Within 2 calendar days for urgent, symptomatic, but not life-threatening care
- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Mental Health Providers:

- Within 30 calendar days for routine, non-urgent appointments
- Within 2 calendar days for urgent, symptomatic, but not life-threatening care
- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Substance Use Disorder Providers:

- Within 30 calendar days for routine, non-urgent appointments
- Within 2 calendar days for urgent, symptomatic, but not life-threatening care
- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Hospitals:

- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Pharmacies:

- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Dental Providers:

- Within 45 calendar days for routine, non-urgent appointments
- Within 2 calendar days for urgent, symptomatic, but not life-threatening care
- Emergency dental treatment no later than 48 hours, or earlier as the condition warrants, of injury to sound natural teeth and surrounding tissue and follow-up treatment by a dental provider
- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Specialty Providers:

- Within 30 calendar days for routine, non-urgent appointments
- Within 2 calendar days for urgent, symptomatic, but not life-threatening care

- ≤ 30 miles of travel in urban areas
- ≤ 75 miles of travel in rural/frontier areas

Provider Directory

As a credentialed and participating provider, your name and provider demographics are included in the provider directory, which is available to members and featured on our website, www.BCBSND.com under “Find a Doctor.” Listings are updated weekly. BCBSND makes every effort to ensure the information in the provider directory is current and accurate, based on the information provided to us.

Provider directory information includes demographic information such as medical school attended and graduation year, residency, gender, languages spoken and whether a practitioner’s office is accepting new patients. Other information like a provider’s specialties, board certifications, hospitals where they admit accreditation information and web address may also be available.

Provider Change Notification

Please notify Credentialing & Provider Data Management if any of the following changes occur:

- Contact information
- New providers join your practice
- New tax ID number is obtained
- Providers in your clinic retire or terminate employment
- Business or practice closes or merges
- NPI number changes
- Address, phone or fax number changes
- Status regarding accepting new patients changes
- Office languages spoken, patient gender or age restrictions updates
- A provider’s specialty or board certification has changed for any active service location
- Address for 1099

Changes can be made by submitting a request to Credentialing & Provider Data Management:

- Online: www.BCBSND.com/web/providers/forms
- Email: prov.net@bcbsnd.com
- Fax: 701-282-1910
- Mail:
  ATTN: Credentialing & Provider Data Management
  4510 13th Ave. S.
  Fargo, ND 58121

Refer Members to Participating Providers

Participating providers agree to assist with BCBSND's efforts to keep member costs down. One way to do that is to refer our members – your patients – to other participating providers.

Referring to participating providers is important because members may pay significantly more when using a nonparticipating provider. The amounts that some nonparticipating providers charge for their services are higher than the fees participating providers have agreed to accept. When seeing a nonparticipating provider, the member may be responsible for the difference between the fee schedule amount and the billed charge. To confirm if a provider is participating, please consult our Find a Doctor tool at www.BCBSND.com.

Federal Employee Program

The numerous independent BCBS companies across the United States, through their participation in FEP, insure 4 million federal government employees, dependents and retirees. FEP is the largest private health insurance contract in the world. 65 percent of all federal employees and retirees who receive their health care through the government's Federal Employee Health Benefits Program (FEHBP) are members of an independent BCBS company. BCBSND participates in the FEP program for federal employees located in North Dakota.

The website at www.fepblue.org is devoted exclusively to FEP. Because the Office of Personnel Management negotiates the benefits and premiums of this plan annually on a nationwide basis, the benefit information is updated each year. A printable PDF file may be downloaded from the website for future reference.

Up-to-date information on providers, pharmacy programs and resources, such as Blue Health Connection, a 24-hour nurse telephone service, also is available on this site. Newsletters provide health and benefit information for federal employees, including those who are overseas. Links to health-information sites also are listed.

For more information, call FEP Customer Service at 800-548-4026 or 701-282-1468.

Medicare Advantage (MA) Members from NextBlue of North Dakota (NextBlue) and Out of State MA Blue Plans

Government rule changes effective in 2009 enable health plans to enroll and cover some retiree group members in Medicare Advantage (MA) HMO or PPO products. NextBlue of North Dakota began January 1, 2021, providing services to our enrolled Medicare Advantage members in North Dakota. NextBlue of North Dakota information can be found at www.nextbluend.com- MA members who are enrolled in NextBlue are encouraged to seek services with a participating NextBlue can be seen at any facility. Out-of-state MA plan members in areas without a provider network are "non-network members," and may receive care from any Medicare eligible provider, including all Medicare participating providers.

BCBSND network providers are currently encouraged, but not required, to provide services to non-network members. Should you decide to provide services to a MA member, you will be

reimbursed for covered services at the “Medicare Allowed Amount” based on where the services were rendered and under the member’s out-of-network benefits. Providers should continue to verify eligibility and bill for services for any out-of-state Blue Plan member they agree to treat. Claims are to be submitted directly to NextBlue of North Dakota

Based on CMS regulations, providers who accept Medicare assignment and provide services to a Medicare Advantage member for whom they have no obligation to provide services under the contract with a Blue Plan -are generally- considered a non-contracted provider and be reimbursed the equivalent of the current Medicare payment amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). This amount may be less than your charge amount. Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) who are non-contracted providers. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

NextBlue of North Dakota Insurance Company is an independent licensee of the Blue Cross Blue Shield Association.

Frequently Asked Questions Regarding Treatment of Medicare Advantage Members

How do I identify a Medicare Advantage member?

Medicare Advantage (MA) members have distinctive product logos on their medical ID cards to help you recognize them. All logos have Medicare Advantage in the design.

What steps do I need to take when providing services to a non-network member?
Verify eligibility by contacting BlueCard Eligibility at 800-676-BLUE (2583). Be sure to ask if MA benefits apply.

Why is correct Medicare Advantage billing important?
Providers treating MA members must ensure that they send in clean claims with all necessary data to NextBlue according to the Medicare Managed Care Manual.

The data elements identified below must be included on MA claims sent to BCBSND (prior to January 1, 2021) and NextBlue (January 1, 2021 to present) to ensure that claims will be paid accurately and timely. The Centers for Medicare & Medicaid Services (CMS) already require providers to bill with these elements for traditional Medicare.

What happens if I don’t include these data elements on claims?
Failing to provide the necessary data elements on a claim, when applicable, may delay payment of the claim. We may have to - return the claim to you.

Where do I submit the claim?
You should submit the claim to NextBlue using your current billing practices. Do not bill Medicare directly for any services rendered to a MA member.

How will I be paid for services rendered to a non-network member?
Non-network members' claims are adjudicated according to the benefits that their health plan provides. The claims are paid according to CMS guidelines. At a minimum, eligible claims are reimbursed at the Medicare Allowed Amount based on where the services were rendered and under the member's out-of-network benefits.

What is the Medicare Allowed Amount?
The Medicare Allowed Amount is the fee schedule reimbursement that Medicare would pay to a provider who accepts assignment of benefits for services rendered to a member.

Who do I contact if I have a question about the data elements?
If you have any questions regarding the MA program or products, contact NextBlue Provider Service at 844-753-8039.

Providers must include the following data elements on Medicare Advantage claims, when applicable:

Element	Facility Claim Form	Professional Claim Form
Taxonomy Code (if you represent an institution with more than one subpart to bill)	X	
National Provider Identifier	X	X
Service Location 9-digit ZIP Code (if different than Billing Provider ZIP Code)	X	X
Treatment Code Information (for Home Health Claims)	X	
Height and Weight for ESRD Patients	X	X
Core Based Statistical Area (for Home Health and ESRD claims)	X	
Ambulance Pick-Up 9-digit Zip Code	X	X
Source of Referral for Admission (for Home Health Claims) (One Alpha numeric character indicating transfer or admission)	X	
Source of Referral for Admission (for Home Health Claims) (One Alpha numeric character indicating transfer or admission)	X	

Element	Facility Claim Form	Professional Claim Form
Source of Referral for Admission (for Home Health Claims) (One Alpha numeric character indicating transfer or admission)	X	
Source of Referral for Admission (for Home Health Claims) (One Alpha numeric character indicating transfer or admission)	X	
Source of Referral for Admission (for Home Health Claims) (One Alpha numeric character indicating transfer or admission)	X	

ELECTRONIC CLAIMS SUBMISSION & PAYMENT

Availity Essentials Provider Portal

Availity Essentials is a multi-payer site where you can use a single user ID and password to work with BCBSND and other participating payers online. The Availity Essentials Intelligent Gateway offers a full suite of Electronic Data Interchange (EDI) services such as, but not limited to, the ability to check eligibility and benefits, manage claims and remittances, request authorizations. BCBSND has an Availity Essentials webpage to help providers navigate the tools and functionality available https://www.bcbsnd.com/providers/news-resources/availity-essentials. Availity Essentials is compliant with all HIPPA regulations and there is no cost for providers to register or use any of the online tools.

For more information beyond what is outlined on the BCBSND Availity Essentials webpage, please visit the Availity Essentials portal directly at www.availity.com. If you have any problems, you can contact Availity Essentials at 1-800-282-4548.

Electronic Funds Transfer

Electronic Funds Transfer (EFT) is a provider service where BCBSND deposits your payment directly into your checking account. EFT is a free service to participating providers, which eliminates the mail time associated with the delivery of your remittance advice and check, as well as the time-consuming task of making a manual deposit to your bank.

Participating providers are required to register to receive electronic payment listings, thus would be eligible for EFT. If you are not currently receiving electronic payment listings, there are links to guide you in the setup process.

CLAIMS SUBMISSION

All providers are encouraged to submit their claims electronically. If you are interested in pursuing electronic submission of claims, review the BCBSND Availity Essentials webpage and/or contact Availity Essentials directly. Please refer to the Electronic Claims Submission & Payment section of this manual for more information.

As a participating provider, you agree to file claims for BCBSND members. We recognize coding from Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and ICD-10-CM coding manuals. On average, claims without submission errors can take up to 30 days to process. If it has been longer than 30 days and a claim has not yet finalized, contact the Customer Contact Center by calling the number on the back of the member ID card.

As a BCBSND participating provider, you may only bill the member for non-covered services and cost sharing amounts identified as billable on the payment listing from BCBSND. Cost sharing amounts include coinsurance, copayment and deductible amounts.

Benefit inquiries and claims questions can be directed to our Provider Service department at 800-368-2312 or 800-548-4026 for FEP — benefit plan numbers that begin with a single alpha "R" followed by numeric digits, typically eight.

All completed claim forms should be forwarded to the following address for processing:

- Blue Cross Blue Shield of North Dakota
  4510 13th Ave. S.
  Fargo, ND 58121-0001

FEP claims should be mailed to:

- Blue Cross Blue Shield of North Dakota
  ATTN: FEP
  4510 13th Ave. S.
  Fargo, ND 58121-0001

Tips for Submitting Paper Claims

All providers are encouraged to submit their claims electronically. If you are interested in pursuing electronic submission of claims, please visit www.availity.com to register. Please refer to the Electronic Claims Submission & Payment section of this manual. If electronic claims submission is not an option, paper claims must be submitted according to the following guidelines. This will ensure timely and accurate processing of claims through the Optical Character Recognition (OCR) system.

For professional paper claims:

- Use red CMS-1500 claim forms, version 02/12.
- Photocopies of claims are not acceptable through the OCR system.
- Print claims in a 10-12 pitch or 10-12-point font, using a dark black printer ribbon or black ink jet or laser print. Handwritten claims are not accepted.

- Avoid the use of red pen, markers, or blue/green highlighters. The OCR equipment drops all red print when processing and any information written in red will “drop out” and be missed.
- Align the claim form so that all information is contained within the appropriate box. Poorly aligned data may be read incorrectly or missed entirely, resulting in incorrect processing of the claim and/or the claim being returned
- Use ALL CAPS when printing the information.

The following tips will ensure prompt and accurate OCR translation of your CMS-1500 claims:

- **Item 1a** should contain the patient’s benefit plan number. Submit the alpha prefix and patient’s benefit plan number that is in effect at the time services are provided. A space should not be placed between the alpha prefix and the patient’s benefit plan number.
- **Item 3** should contain the patient’s birth date and sex. The patient’s birth date should be shown in the MMDDCCYY format. Enter an “X” in the appropriate box designating the sex of the patient.
- **Item 4** should contain the subscriber’s name. The name should be shown as LAST name, FIRST name, MIDDLE INITIAL with spaces between. For example, “Jane A. Doe” should be shown as “DOE JANE A”. Do not list this item as “SAME” when the patient is the same as the insured. This is also true for item S (Patient’s Address) and item 7 (insured’s Address).
- **Item 6** should contain the patient’s relationship to the insured. Enter an “X” in the appropriate box designating the patient’s relationship to the insured.
- **Item 17b** should include the NPI number of the referring, ordering, or supervising provider.
- **Item 21** should include no more than 12 ICD 10 diagnosis codes. Enter up to twelve diagnosis codes in order of priority (A, B, C, D, E, F, G, H,1, J, K, L) using the degree of specificity. Descriptions of the ICD 10 code should not be included.
- **Item 24A** must include a date of service for each detail line. If “From” and “To” dates are the same for a detail line, show date (MMDDYY) in the “From” and “To’’ columns.
- **Item 24B** must include a valid two-digit place of service.
- **Item 24D** enter the CPT or HCPCS code(s) and modifier(s) from the appropriate code set in effect on the date of services. This field accommodates the entry of up to four two-digit modifiers.
- **Item 24E** should include only the diagnosis pointers referencing the appropriate ICD-10-CM code in item 21. ICD-10-CM codes should not be included in item 24E.
- **Item 24F** enter the charge for each listed service.
- **Item 24G** enter the number of days or units for each line item service.
- **Item 24J** enter the NPI of the rendering provider or facility. Laboratories, ambulatory surgery centers and other facilities where outside providers come to provide services must list the facility NPI as the rendering provider in 24J. The provider performing the service must bill for their services separately.
- **Item 28** should include the billed amount for that claim. The dollar amount should be to the left of the broken line and the cent amount should be to the right of the broken line. Do not enter “continued” and do not include charges from another page in the total charges.

- **Item 32a** must include the NPI of the location where services were provided.
- **Item 33a** must include the NPI of the billing provider.

The CMS-1500 claim form is designed for only six detail lines of information. If more than six detail lines of information are required, you must submit another CMS-1500 claim form with the additional data. Each claim form will be considered as a separate claim and must be totaled separately.

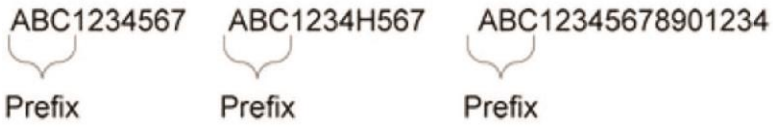
Verifying Member ID Cards

To help ensure prompt and accurate claims processing, please make sure you have a copy of the patient's current ID card and use that information when submitting claims. As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff

Blue Plan members' ID cards include a three-digit prefix in the first three positions of the member's ID number. This prefix identifies the member's Blue Plan and is critical for eligibility, benefits verification and claims processing. This may be followed by up to 14 additional characters; any combination of letters and numbers. When filing the claim, always enter the identification number exactly as it appears on the member's card, inclusive of the prefix.

Examples of ID numbers:



Member ID numbers must be reported exactly as shown on the ID card. Do not add, omit or alter any characters from the member ID number.

Remember to include the correct Patient Relationship Code to ensure your payment listing shows the claim is processed under the correct member.

Code	Title
01	Spouse
18	Self
19	Child
20	Employee
21	Unknown

Code	Title
39	Organ Donor
40	Cadaver Donor
53	Life Partner
G8	Other Relationship

Timeframe for Claims Submission

BCBSND claims must be filed within 12 months, or length of time stated in the member's benefit plan, of the date of service. Claims received after 12 months, or length of time stated in the member's benefit plan, will be denied, and the member and BCBSND should be held harmless for these amounts.

Self-insured plans and plans from other states may have different timely filing guidelines. To determine what the claims filing limits are for your patients, please call Provider Services at 800-368-2312 or 800-548-4026 for FEP claims.

Contiguous Counties

Claims filing rules for counties bordering North Dakota

For providers located in counties of states that border North Dakota (Minnesota, Montana and South Dakota) the claims filing rules are:

- If a member has insurance coverage with BCBSND and receives services from a health care provider located in a bordering county, which is participating with BCBSND, the provider must follow the contiguous guidelines
- If a health care provider in a bordering county is not participating with BCBSND but is participating with the Blue Cross Blue Shield plan where the provider is located and provides services to a member with coverage from BCBSND, the provider must file claims to the local Blue Cross Blue Shield plan
- If a health care provider located in a county bordering North Dakota, which is participating with BCBSND, provides care to a member with insurance from a Blue Cross Blue Shield Plan other than BCBSND, the provider must file the claim to the local Blue Cross Blue Shield Plan, as the "Host Plan"

The exceptions to these rules apply to health care providers for lab, durable medical equipment, medical supplies and specialty pharmacy.

Example 1:
Provider is located in one service area and has contracts with both Plans.

- Dr. Smith is located in North Dakota (ND) and has a contract with ND
- Dr. Smith also has a contiguous area contract with Minnesota (MN)
- Dr. Smith files a claim to MN for a MN member who resides or works in MN to MN. It's a local MN in-network claim

- Dr. Smith files a ND member's claim to ND. It's a local ND in-network claim
- Dr. Smith files claims for a MN member who doesn't reside or work in MN or any other Plan's member to ND; regular BlueCard claims filing rules apply. It's a BlueCard in-network claim

Example 2:
Provider is located in one service area and has a contract only with the Plan in this service area.

- Dr Smith is located in ND and has a contract with ND
- Dr. Smith has no contiguous area contract with MN
- Dr. Smith files a ND member's claim to ND. It's a local ND in-network claim
- Dr. Smith files claims for a MN member and any other Plan's member to ND; regular BlueCard claims filing rules apply. It's a BlueCard in-network claim

Example 3:
Provider is located in both service areas and has contracts with Plans in both service areas.

- Dr. Smith has an office in ND in an area contiguous to MN and an office in MN in an area contiguous to ND
- Dr. Smith has a contract with ND; Dr. Smith has a contract with MN
- Dr Smith sees a ND member in his ND office. The claim is filed to ND. It is a local ND in-network claim
- Dr. Smith sees a MN member who resides or works in MN in his ND office. The claim is filed to MN. It is a local MN in-network claim
- Dr. Smith sees an Illinois (IL) member or MN member, not residing or working in MN, in his ND office. The claim is filed to ND; regular BlueCard claim filing rules apply. It's a BlueCard in-network claim

For more information on the BlueCard program, please visit our website under BCBS Programs.

BlueCard® Program

The BlueCard Program links participating providers and the independent BCBS Plans across the country and abroad with a single electronic network for claims processing and reimbursement. The program allows BCBS participating providers in every state to submit claims for members who are enrolled through another Blues Plan to their local BCBS Plan.

You should submit claims for BCBS members (including Blue Cross only and Blue Shield only) visiting you from other areas directly to BCBSND. BCBSND is your sole contact for all BCBS claims submissions, payments, adjustments, services and inquiries.

How to Identify BlueCard Members

When out-of-area BCBS members arrive at your office or facility, be sure to ask them for their current membership ID card. The two main identifiers for BlueCard members are the prefix and a "suitcase" logo.

Prefix

The three-character prefix of the member's identification number is the key element used to identify and correctly route out-of-area claims. The prefix identifies the Blue Plan or the national account to which the member belongs. There are three types of prefixes: plan-specific, account-specific and international:

1. Plan-specific prefixes are assigned to every BCBS Plan and start with X, Y, Z or Q. The first two positions indicate the plan to which the member belongs while the third position identifies the product in which the member is enrolled.

2. Account-specific prefixes are assigned to centrally processed national accounts. National accounts are employer groups with offices or branches in more than one area but offer uniform coverage benefits to all their employees. Account-specific prefixes start with letters other than X, Y, Z or Q. Typically, a national account prefix will relate to the name of the group. All three positions are used to identify the national account.
3. Occasionally, you may see ID cards from foreign BCBS members. These ID cards will also contain three-character prefixes. For example, "JIS" indicates a Blue Cross Blue Shield of Israel member. The BlueCard claims process for international members is the same as that for domestic BCBS members.

International Blue Plan Members

Occasionally, you may see identification (ID) cards of Blue Plan members from a foreign country. These international ID cards will contain prefixes similar to cards of domestic Blue Plan members. International Blue Plan members should be treated the same as domestic Blue Plan members.

For international Blue Plan members, follow the same steps that you would for domestic Blue Plan members:

1. Verify eligibility and benefits using one of three methods: send an electronic inquiry through the Availity Essentials Provider Portal, submit a HIPAA 270 transaction (eligibility) to BCBSND, or call the BlueCard Eligibility® line at 800-676-BLUE (2573) and provide the prefix
2. File claims to BCBSND; we are your contact for claims collection, payment and problem resolution for healthcare claims incurred by international Blue Plan members
3. Follow the same payment collection practice as you do for domestic members. Be sure to collect payment for non-covered services. These members may not have coverage for non-emergency outpatient or physician services. In these instances, you should collect payment for non-covered services only from the members

Note: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the United States. Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard

Program. Please follow the instructions of these plans and those, if any, on their ID cards for servicing their members. The Blue Cross Plans in Canada are Alberta Blue Cross, Manitoba Blue Cross, Atlantic Blue Cross Care, Quebec Blue Cross, Saskatchewan Blue Cross and Pacific Blue Cross.

Please contact Provider Service at 800-368-2312 or 701-282-1090 for further information or if you are unsure about your participation status.

ID cards with no Prefix

Some ID cards may not have a prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member's ID card for information on how to file these claims. If that information is not available, call Provider Services at 800-368-2312.

"Suitcase" Logo

BlueCard PPO offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a provider or hospital designated as a BlueCard PPO provider. Members are identified by the "PPO in a suitcase" logo on their ID card.

This logo on an ID card identifies a member who has purchased a Blue Card product on a public exchange.

HMO patients serviced through the BlueCard Program

In some cases, you may see BCBS HMO members affiliated with other BCBS Plans seeking care at your office or facility. You should handle claims for these members the same way you handle claims for BCBSND members and BCBS PPO patients from other Blue Plans—by submitting them through the BlueCard Program. Members are identified by the "empty suitcase" logo on their ID card.

BlueCard members throughout the country have access to information about participating providers through BlueCard Access, a nationwide toll-free number 800-810-BLUE (2583) that allows us to direct patients to providers in their area. Members call this number to find out about BlueCard providers in another Blue Plan's service area .You can also use this number to get information on participating providers in another Blue Plan's service area.

How the Program Works

Member coverage is verified through Availity Essentials. It is important to have all members show their most recent identification cards for an accurate response for their current plan.

1. You may verify the member's coverage on Availity Essentials or by calling BlueCard Eligibility at 800-676-BLUE (2583). An operator will ask you for the prefix on the member's ID card and will connect you to the appropriate membership and coverage unit at the member's plan. If you are unable to locate a prefix on the member's ID card, check for a phone number on the back of the ID card, and if that's not available, call Provider Services at 800-368-2312.

2. After you provide services to a BCBS member, you should file the claim according to your contractual arrangements. If you contract directly with the member's Blue Plan, file the claim directly to that plan. For authorizations, see the member's ID card.

Reminder: The claim must be filed using the prefix and identification number located on the patient's ID card.

3. Once the claim is received, BCBSND electronically routes it to the member's own independent BCBS Plan.
4. The member's plan adjudicates the claim and transmits it to BCBSND, either approving or denying payment. The processing time of the claim may take longer than most BCBSND processes.
5. BCBSND reconciles payment and forwards it to you according to your payment cycle. Generally, when a claim is submitted to BCBSND from a contracted participating provider, then reimbursement is based on North Dakota fee schedule amounts. If the services are performed out of the area and submitted to another state or Blues plan, then the reimbursement would be based on the arrangements that the provider has with the out of state Blues plan. This can depend on the type of coverage that is indicated on the members Blue Cross Blue Shield plan.
6. The member's local Blue Plan sends a detailed Explanation of Benefits (EOB) report to the member.

BlueCard Claims Submission

Hardcopy Claims can be mailed to:
BCBSND Claims Department
4510 13th Ave. S.
Fargo, ND 58121-0001

Ancillary Claims Filing Instructions for BlueCard Claims

Ancillary claims for Independent Clinical Laboratory, Durable (Home) Medical Equipment (DME) and Supply, and Specialty Pharmacy are filed to the Local Plan in whose service area the ancillary services were provided—if these services were performed in North Dakota, the Local Plan is BCBSND.

- Lab Local Plan is the plan in whose service area the referring provider is located
- DME Local Plan is the plan in whose service area the equipment was shipped or purchased at a retail store
- Specialty Pharmacy Local Plan is the plan in whose service area the ordering physician is located

Easy Access to Medical Policy and Precertification/Precertification Information for Out-of-Area Blue Members

If calling 800-676-BLUE (2583) to obtain precertification only:

When precertification for a specific member are handled separately from eligibility verifications, your call is routed directly to the area that handles precertification. You will choose from four options regarding the type of service for which you are calling:

- Medical or surgical
- Behavioral health
- Diagnostic imaging or radiology
- Durable medical equipment (DME)

Upon making your selection, you will be transferred to the appropriate area of the member's plan to service your specific request.

Call 800-676-BLUE (2583) to obtain eligibility only or if you need both eligibility and precertification:

Select the option to obtain eligibility and precertification information. Your eligibility inquiry will be addressed and then you will be transferred, as appropriate, to the precertification area.

If you have any questions about the BlueCard Eligibility line (800-676-BLUE), please call Provider Service at 800-368-2312.

This does not apply to FEP or Medicare Advantage.

Procedure and Diagnosis Codes Guidelines

CPT, HCPCS and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes must be used as well as coded to the required level of specificity. Services are billed based on the definitions, units and parenthetical information as identified by the American Medical Association (AMA) for CPT and the CMS for HCPCS. Code sets are updated based on release of new codes by the owners of the code sets (AMA, CMS, etc.). Codes cannot be used prior to their effective date or after their termed date.

Participating providers should follow the coding guidelines published in the current editions of the CPT, ICD-10-CM and HCPCS code books when submitting claims to BCBSND for processing. BCBSND follows these coding guidelines unless otherwise identified in our policies.

ICD-10-CM (Diagnosis Codes)

Always report the primary diagnosis code on the claim form. Principal Diagnosis – "Reason for service or procedure."

- Report up to twelve diagnosis codes on the same claim form.
- Report all digits of the appropriate ICD-10-CM code(s).
- Report the date of accident if the ICD-10-CM code is for an accident diagnosis.
- All ICD-10 codes start with an alpha character.
- Some three-character code groupings stand alone as the valid code for the condition.
- Do not add zeros to make codes seven characters long

ICD-10-PCS (Procedure Code Structure)

- ICD-10-PCS codes are only used for inpatient hospital claims.
- ICD-10 PCS is comprised of seven alphanumeric characters.
- Each character contains up to 34 possible values, which represent a specific option for the general character definition.
- The 10 digits 0-9 and 24 letters A-H, J-N, and P-Z may be used in each character.
- The letters O and I are not used to avoid confusion with the digits 0 and 1.

Add-on Codes

“Add-on” codes describe procedures or services that are always performed in addition to the primary procedure or service. They describe additional intra-service work associated with the primary procedure or service. Such services would never be reported using stand-alone codes.

These additional or supplemental procedures are designated as “add-on” codes and identified in CPT with a + symbol (listed in Appendix E of CPT). Add-on codes can also be identified by specific language in the code descriptor, such as “each additional” or “(List separately in addition to primary procedure).”

Only codes with the add-on code designation (i.e., preceded by a + symbol include descriptive language in the code descriptor, or arc included in Appendix E) are considered add-on codes. Codes that precede or follow a designated add-on code are not automatically considered add-on codes. Add-on codes are exempt from the multiple procedure concept, and therefore, modifier ‘-51’ cannot be appended to these codes.

The following criteria are used to identify add-on codes in CPT:

- The service or procedure can never serve as a stand-alone code and must be reported in conjunction with another primary service or procedure.
- The service or procedure is commonly carried out in addition to the primary service or procedure performed. If not commonly performed in addition to the primary service or procedure, it is then defined as a stand-alone code; and when performed in addition to another procedure, the modifier -51 should be appended.
- The service or procedure must be performed by the same physician.
- The add-on code describes additional anatomic sites where the same procedure is performed (e.g., reoperation, additional digit[s], lesion[s], neurorrhaphy[s], vertebral segment[s], tendon[s], and joint[s]).
- The add-on code describes a special circumstance under which a specific service or procedure is performed in conjunction with the primary procedure.
- The add-on code describes an additional segment of time in a time-based code (e.g., each additional 30 minutes).

Trailing - T Codes

The AMA developed CPT Category III codes to track the utilization of emerging technologies, services and procedures. The existence of any CPT Category III codes does not establish a service or procedure as safe, effective or applicable to the clinical practice of medicine. BCBSND considers all CPT Category III codes not covered unless a BCBSND medical policy specifically extending coverage to a particular CPT Category III code has been published. Claims submitted with CPT Category III codes that do not have a medical policy will be denied as investigational.

If a provider believes that a CPT Category III code should qualify for coverage (e.g., the service has been proven safe and effective as well as reasonable and necessary), a request for review through the BCBSND medical policy development process may be initiated by submitting the BCBSND Technology Assessment Evaluation form. This form is available at bcbsnd.com.

Copies of the clinical references and peer-reviewed specialty guidelines must be submitted with the Technology Assessment Evaluation form.

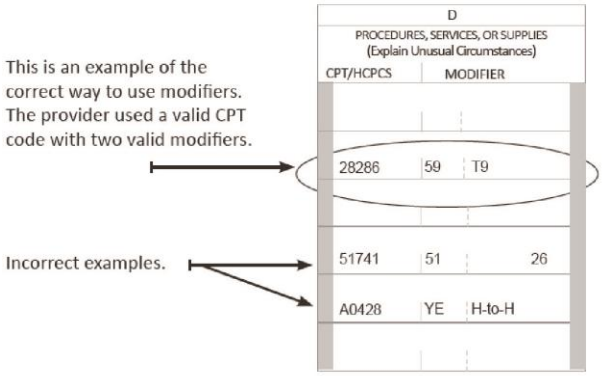
Modifiers

A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

To ensure you receive the most accurate payment for services rendered, use the appropriate modifiers when filing the claim. Append applicable modifier(s) in Block 24D of the CMS-1500 claim form. If necessary, please submit medical records with your claim to support the use of a modifier.

Please use the following tips to avoid the possibility of rejected claims:

- Indicate the valid modifier in Block 24D
- List up to four modifiers per CPT and/or HCPCS code.
- Do not use other descriptions in this section of the claim form. In some cases, the system may read the description as a set of modifiers and this could result in lower payment.
- Avoid excessive spaces between each modifier.
- Do not use dashes, periods, commas, semicolons or any other punctuation in the modifier portion of Block 24D



If you have any questions about billing with modifiers, please call Provider Service at 800-368-2312 or 800-548-4026 for the Federal Employee Program.

National Provider Identifier (NPI)

HIPAA requires the use of a standard unique identifier for health care providers. CMS has assigned NPIs to comply with this requirement. NPIs are issued by the National Plan and Provider Enumeration System (NPPES). This one unique number is to be used when filing claims with BCBSND as well as with federal and state agencies, thus eliminating the need to use different identification numbers for each agency or health plan.

All organizations submitting claims to BCBSND must use an organizational NPI and Tax Identification Number (TIN), where applicable. Each practitioner being credentialed or recredentialed must include their individual NPI on the application.

For more information, including who should apply for an NPI and how to obtain your NPI, visit www.BCBSND.com/web/providers/new-provider/apply and click “Completing an NPI Application,” which will direct you to the National Plan & Provider Enumeration System website. If you have any questions about the NPI relating to your BCBSND participation, please contact Credentialing & Provider Data Management via email at prov.net@bcbsnd.com or call toll free: 800-756-2749.

NPIs can be placed in three locations on the CMS-1500 claim form to identify the rendering provider/facility, service location, and where payment should be sent. (Electronic claim submitters should refer to the Companion Guide for information on where to place these NPIs.)

- Box 24J – this field contains the NPI of the rendering provider or facility.

Facility NPI’s must be listed as the billing NPI for laboratories, ambulatory surgery centers and radiology services. The provider performing the service must bill for their services separately.

- Box 32a – this field contains the NPI of the location where services were provided.
- Box 33a – this field contains the NPI of the billing provider.

To correctly submit 837 Professional Claims to BCBSND, the billing, referring and rendering provider NPI must be included in the correct form locator.

- Billing Provider's NPI - Form Locator 33a or Loop 2010AA Segment NM1, Element 09
- Referring Provider NPI - Form Locator 17 and 17b or Loop 2310A, Segment NM1, Element 09
- Rendering provider NPI - Form Locator 24j or Loop 2310B, Segment NM1, Element 09
- Billing Provider Taxonomy Code - Loop 2000A, Segment PRV, Element 03

Coordination of Benefits

Coordination of Benefits (COB) occurs when a member is covered by two or more insurance plans. When COB is involved, claims should be filed with the primary insurance carrier first. When an Explanation of Benefits (EOB) is received from the primary carrier, the claim then should be filed with the secondary carrier, attaching the primary carrier EOB.

When any of the below bulleted items are identified, the claim submitted to BCBSND may be denied:

- An EOB is not attached
- Information on other insurance coverage cannot be verified
- The member does not respond to our request for additional information

Receiving COB information from members before their claims are filed may reduce processing and payment delays.

For a member with coverage under two BCBSND benefit plans, BCBSND will cross the primary claim over to the secondary coverage for processing. Therefore, providers should not submit a claim to the secondary benefit plan.

When a member has coverage under BCBSND and another insurance plan, claims should be submitted to the primary plan first. Once the claim to the primary plan has processed, a second claim should be submitted to the secondary plan with a copy of the primary plan's EOB.

Coordination of Benefits (COB) Guidelines

In an effort to decrease the number of claims being reprocessed and to ensure accurate and timely reimbursement, the following claims submission guidelines must be followed:

- Submit the correct accident date in box 14 of the CMS-1500 claim form or the occurrence code and date in box 32 of the UB-04 claim form.
- Indicate if services are a result of work or auto injury in box 10 of the CMS-1500 claim or in the remarks field on the UB-04 claim form. If services are work related, you must submit the EOBs from the workers compensation carrier with the claim to BCBSND. If workers compensation paid the services in full, the claims and EOBs do not need to be submitted.
- Submit the diagnosis pertinent to that visit only.
- To avoid refunds and reprocessing, submit claims after all late charges and credits are included.
- BCBSND will automatically process claim(s) for patients with duplicate BCBSND coverage. Do not resubmit claims for the secondary plan.
- Primary insurance payment information amounts must be entered in loop 2430

- Submit the appropriate modifier(s) where applicable. The appropriate use of modifiers will allow more claims to be paid without additional information. It will also prevent inappropriate denials for duplicate services. This is especially helpful when coordinating benefits for accident or injury care.
- Do not submit a new claim with other insurance carrier's payment if BCBSND has previously processed a claim for the services. An adjustment request should be submitted on the original claim.

Example:
If a patient has workers compensation benefits for an injury to the left knee (LT) but requires a procedure done to the right (RT) knee not related to the workers compensation injury, the use of the LT and RT modifiers will indicate the services are different. This will prevent claims from being delayed for coordination of workers compensation benefits.

BlueCard Coordination of Benefits

In some situations, providers receive a payment higher than expected from an out-of-state Blue Cross Blue Shield plan paying as secondary to a primary commercial payer. These situations occur when the secondary payer does not apply the provider discounts as calculated by the primary payer. BCBSND does not anticipate or expect repayment of these funds from the provider. The provider may use the money to offset the provider discount as calculated by the primary payer, if not prohibited by the provider's contract with the primary payer. However, the secondary out-of-state plan retains the right to request a future recoupment if they determine an incorrect payment was made (i.e., the member was not eligible on the date of service).

Providers are not required to submit a Claim Adjustment Request for a refund if the following criteria are met:
- The provider originally submitted the claim, including the primary carrier's Explanation of Benefits, to BCBSND to process through the BlueCard system as the secondary payer.
- The secondary BCBS plan processed the claim without applying primary provider discounts.
- Payments by all sources, including the primary payer, secondary payer and member, do not exceed billed charges (or Diagnosis-Related Group, if higher).

If the secondary payer calculates a member cost share that is higher than the primary payer, providers must use the primary payer's cost-share amount. In addition, any secondary payer overpayments must be used to pay for the primary payer cost share first before applying any remainder to the primary payer's discounts.

If you have further questions regarding patient responsibility or overpayments, contact Provider Service at 800-368-2312.

Subrogation

Subrogation is a contract provision that allows health care insurers to recover all or a portion of claims payments if the member is entitled to recover such amounts from a third party.

The third party's liability insurance carrier normally makes these payments. A third party is another carrier, person or company that is legally liable for payment from the treatment of the claimant's illness or injury.

All claims you submit to BCBSND must indicate if work-related injuries or illnesses are involved and if the services are related to an accident.

Accident/Workers' Compensation

These claims, BCBSND follows a "pursue and pay" process. This means BCBSND will first do its due diligence in determining if the claim is related to an on-the-job accident and then pay the claim. For accident claims, the claims system auto-generates a member-specific letter when such a claim is received. The claim is suspended for 10 business days, waiting for the member to return the requested information. If no response is received during that time, the claim will be systematically rejected as member liable, indicating BCBSND is waiting for information from the member.

Medicare Supplemental Claims

To reduce the administrative expense and time involved with manual claims submission, in most cases, Medicare supplemental claims will automatically cross over to BCBSND and you do not need to file a claim for the BCBSND portion to be processed.

For out-of-state BCBS members

Blue Cross Blue Shield plans may receive crossover claims for providers who are not within their service area. All claims for out-of-state Blue Cross Blue Shield plan members will be processed by the out-of-state Blue plan listed on the member's ID card.

How to determine if the claim was crossed over from Medicare

If a claim is crossed over, you will receive a message beneath the patient's claim information on the remittance advice that indicates the claim was forwarded to the carrier.

Example 1: "Claim information forwarded to: BCBSND-Supplemental"

Example 2: "Claim information forwarded to: BCBS of Nebraska"

If the remittance does not contain a message similar to the above, the claim was not crossed over to the payer. This claim must be filed on paper to the plan listed on the member's ID card.

The following claims are excluded from the crossover process for BCBSND:

- Original Medicare claims paid at 100 percent
- 100 percent denied claims with no additional beneficiary liability
- Adjustment claims that are non-monetary or statistical
- Medicare Secondary Payer (MSP); claims for which other insurance exists for beneficiary
- National Council for Prescription Drug Programs (NCPDP) claims

What to do when the claim was not crossed over from Medicare

- Send the claim along with the Medicare explanation of benefits to the Blue Plan listed on the member's ID card
- Wait 35 days before conducting follow-up

Follow-up on crossover claims

- For BCBSND: Wait 30 days before conducting follow-up on Availity Essentials or contacting BCBSND
- For Blue Cross Blue Shield out-of-state plans: Wait 30 days before contacting the out-of-state plan

If you have any questions or require additional information on Medicare supplemental claims, please contact Provider Service at 800-368-2312.

Claim Adjustments/Correction Process

Professional Claims

Claim/Billing Frequency Type codes are used when billing to indicate whether a claim is a new/original claim or a replacement of a previously adjudicated (approved or denied) claim.

Claim corrections will only be allowed for 180 days from the original claim processing date for both professional and institutional claims unless it is one of the exceptions listed below:

- Medicare
- Coordination of Benefits
- Workers Compensation
- No-fault
- Subrogation
- Third-party Payers

Note: The claim correction process is an electronic-only process. Paper claim corrections received on the CMS-1500 claim form cannot be accepted.

Valid Frequency Type Claims

There are three valid Frequency Type claims that can be initiated:

- Frequency Type 1 is an original claim. All new claims are submitted with this value.
- Frequency Type 7 is a replacement of a prior claim. Frequency Type 7 is used to correct data reported incorrectly on the original claim. The original claim number assigned by BCBSND is required on this type of submission. Frequency Code 7 can be used for changes to diagnosis code, date of service or charges or to add services or remove a line of the claim.
    - If the billing provider needs to be updated, the original claim with the incorrect billing provider will need to be voided as billed in error (Frequency Code 8) and a new claim

(Frequency Type 1) with the new billing provider will need to be submitted. Performing provider numbers can be corrected using Frequency Code 7.

- Frequency Type 8 is a void/cancellation of a prior claim. Frequency Type 8 is used to completely void a claim that was reported in error. The original claim number assigned by BCBSND is required on this type of submission.

Electronic 837P Correction

The 837P allows you to submit a claim adjustment request electronically using a valid Frequency Type code. Corrected claims can be submitted through the Professional or Facility Claim direct claim entry function in Availity Essentials Provider Portal by selecting the Billing Frequency type 7 and providing the original claim number.

Institutional Claims

To make changes to claims that have already been submitted through Availity Essentials, facility providers are to use Adjustment Bill Types XX7 or XX8 for claims previously submitted by paper and electronically.

Guidelines for correction Bill Types XX7 and XX8:

- XX7 Replacement of Prior Claim: This code is to be used when a specific bill or line has been issued and needs to be restated in its entirety. When this code is used, BCBSND will operate on the principle that the original bill is null and void, and that the information present on this bill represents a complete replacement of the previously issued bill. Bill Type XX7 can be used for changes to diagnosis code, date of service or charges or to add services or remove a line of the claim.
    - If the billing provider needs to be updated, the original claim with the incorrect billing provider will need to be voided as billed in error (Bill Type XX8) and a new claim with the new billing provider will need to be submitted. Performing provider numbers can be corrected using Bill Type XX7.
- XX8 Void/Cancel Prior Claim: This code reflects the elimination in its entirety of a previously submitted bill. Use of XX8 will cause the bill to be completely canceled from the BCBSND system.
- The original claim number is required when submitting adjustment bill types XX7 and XX8 on claims and 837I batch and real-time submissions. The original claim number should be reported in the Adjustment Claim Link (ACL) field.

Tip: Submitting Claim Corrections Impacting Two Claims

When submitting a claim correction that impacts two claims, such as adding a modifier on one claim due to a reduction on another claim, use the following:

- Claim 1: Submit frequency 7 to correct data
- Claim 2: Submit frequency 7 to reprocess as a no-change correction

Out-of-State BCBS Members and Fully Rejected Claims

When BCBSND providers see BCBS patients from other states (i.e. BCBSMN, Wellmark, Anthem), these claims are sent to BCBSND and for the dates of service after 07/01/18, these claims are processed under the new HMHS platform.

For these out-of-state member claims, the process for Claim Correction will follow the process outlined above except in the following situation:

- Fully rejected claims for billing guideline rejections (invalid procedure, dx or place of service codes; provider not found issues) – These will need to be submitted as a brand-new claim (frequency 1) that corrects the billing error(s) from the first claim. In these cases, there will be no duplication concerns as the original claim was never identified in the system.

A fully rejected claim can be related to benefits, reimbursement policy, non-covered services under the member's plan, and/or services applied to member liability. In these cases, you would need to submit a claim correction.

Example of a fully rejected claim for billing guidelines:

- A claim for a BCBS of TX member is submitted through the new HMHS platform and the procedure code is invalid. The claim will not complete processing and will be rejected. In this case the provider will see the following information on their remittance advice depending on how many lines are submitted on the claim:
  - One Line:
    - CO16 with remark code M51
  - More than one line and only one line has the invalid procedure code:
  - CO16 with remark code M51 (invalid procedure) for line that has invalid code
    - CO252 with remark code N706 (missing documentation) for the remaining lines

Institutional

Please note that if Bill Type XX7 has previously submitted on an original claim, you are not able to submit another Bill Type XX7 or your claim will reject as a duplicate. If the need to submit a second Bill Type XX7, then you will first need to submit a Bill Type XX8 to void out the original claim with previous corrections.

Once the XX8 claim has finalized, you will need to submit a new claim with the corrections needed. Please note that submitting the new claim to soon, may result in the new claim rejecting as a duplicate.

Professional

Please note that if Frequency Type 7 is submitted on an original claim, you are not able to submit another Frequency Code 7 claim, or it will reject as a duplicate. If a second corrected claim needs to be submitted with a Frequency Code 7, the original claim with previous corrections will need to be voided as billed in error with a Frequency Code 8 claim. Once the

Frequency 8 claim has processed and finalized, you will need to submit a new claim with Frequency 1 to include the corrected changes.

Things to Note

If there are some lines on a claim that paid, then the claim would not be classified as a fully rejected claim.

If providers try to submit a claim correction (rather than a new claim) for a fully rejected out-of-state BCBS member claim, they will receive the following on their remittance advise:

- A claim adjustment group code of CO (contractual obligation)
- A claim adjustment reason code of 16 (claim/service lacks information or has submission/billing errors)
- A remittance advise remark code of N152 (missing/incomplete/invalid replacement claim information)

Submitting NPI & Taxonomy Codes on Claims

BCBSND would like to provide a reminder regarding billing requirements for submitting NPI's and Taxonomy Codes on claims.

- Using the Rendering Provider NPI as the Billing Provider on the claim will cause the claim to reject.
- If the Taxonomy code is not present on the claim, it will hit a front-end edit which will cause the claim to automatically reject.
- For Eligibility and Benefits transactions only, the Organizational NPI should be utilized.
- If an NPI other than the Organization's NPI is used, the transaction will return an "entity not found" error.
- For additional X12 file format instruction, please consult the 5010 implementation guides for the 837I and 837P transactions.

Please review the below chart for the correct breakdown of professional and institutional claim requirements.

Institutional Claims	Professional Claims
To correctly submit 837 Institutional Claims to BCBSND, the billing, pay-to provider, attending physician and operating physician NPI's must be included in the correct form locator. ▪ Billing Provider's NPI - Form Locator 56 or Loop 2010AA, Segment NM1, Element 09 ▪ Pay-to Provider NPI (only used if different from the Billing Provider NPI) - Form	To correctly submit 837 Professional Claims to BCBSND, the billing, referring and rendering provider NPI must be included in the correct form locator. ▪ Billing Provider's NPI - Form Locator 33a or Loop 2010AA Segment NM1, Element 09 ▪ Referring Provider NPI - Form Locator 17 and 17b or Loop 2310A, Segment NM1, Element 09

Locator 2 or Loop 2010AC, Segment NM1, Element 09
- Attending Physician NPI - Form Locator 76 or Loop 2310A, Segment NM1, Element 09
- Operating Physician NPI - Form Locator 77 or Loop 2310C
- Billing Provider Taxonomy Code - Loop 2000A, Segment PRV, Element 03
- Rendering provider NPI - Form Locator 24j or Loop 2310B, Segment NM1, Element 09
- Billing Provider Taxonomy Code - Loop 2000A, Segment PRV, Element 03

DOCUMENTATION

Documentation Requirements

Medical records require appropriate documentation that clearly identifies medical necessity for the services provided and must fully substantiate the ICD-10, CPT and HCPCS® code(s) and modifier(s) being submitted on claims to receive accurate reimbursement.

Documentation in addition to being complete and legible must include at a minimum the following:

- Name of patient and date of service
- Chief complaint or purpose for visit or service
- All services provided such as clinical assessment, examination, procedures performed, and equipment provided
- Treatment plans
- Orders for, intent of and results of all ordered diagnostic services
    - The provider who is treating the patient must order all diagnostic services and the provider must clearly document in the medical record his or her intent that the specific test be performed. The provider who treats the patient is the provider who furnishes an evaluation and management service, treats the patient for a specific medical problem and uses the results in the management of the patient's specific medical problem. Tests not ordered by the treating provider are not reasonable and necessary.
- Refer to the American Medical Association (AMA) coding guidelines for more detail on what should or should not be documented in total time with a patient.
- Date and signature of the rendering provider.

For providers who perform telehealth services, the following information is also necessary to include in the medical dictation when these services are provided. The below information should be included in the documentation each visit. Refer to any applicable telehealth policy as well.

- Documentation supporting medical necessity and appropriateness for the health and service visit.
- Location of the individual and location of the provider.
- Mode of telehealth services provided, such as asynchronous (store-and-forward), synchronous (real time).

- If synchronous telehealth was provided the provider must identify the origination facility name (the site that facilitated the telehealth service).
- If digital online synchronous telehealth was provided the provider must specify that the visit was a digital online visit.

BCBSND requires the locations of the patient and provider during the telehealth service to be recorded in the documentation. To ensure provider safety, should the provider be working from their home office, BCBSND does not require the provider's home address to be included in the patient's medical record, though a notation is required to verify the place where the service was performed.

Failure to meet these requirements may result in claim denial or claims returned for more information.

Diagnostic Imaging

Appropriate utilization and effective communication are critical components of diagnostic imaging. In addition to BCBSND following the ACR Practice Parameter for Communication of Diagnostic Imaging Findings as published in 2014, below are some tips to consider and remember when ordering, documenting and communicating any type of diagnostic imaging result:

- Quality patient care can only be achieved when study results are given in a timely manner to those responsible for the treatment decisions
- An official interpretation (final report) should be completed following any examination, procedure or consultation regardless of the performance site (hospital, physician office, mobile unit, imaging center, etc.)
- Final reports are the definitive means of communicating to the referring physician(s)
- Documentation of radiological studies should be completed on the day the image is read
- Radiology reports become part of the patient's permanent medical record
- Listed below are the required documentation components for radiology reports

Demographics:

- Patient's name
- Valid order from the referring provider for the specific test performed
- Date and time of service
- Name and type of examination
- Facility or location where study was performed
- Name and signature of interpreting provider
- Inclusion of the following additional items is encouraged:
- Dictation date
- Date and time of transcription
- Birth date and age
- Gender

Clinical Information:

- Indication(s) for examination: Reason why the study is being performed and how the results will be used in the patient's plan of care
- Procedures performed and materials used: Description of the studies and procedures performed and any contrast media (including concentration, volume and administration route), medications, catheters or devices used
- Views taken findings:
    - Appropriate anatomic, pathologic and radiologic terminology should be used to describe findings
    - Indication of study quality, i.e., if results are unable to be obtained due to inadequacy of image(s)
    - Pertinent positive or negative findings
    - Impression (conclusion or diagnosis)
    - A precise diagnosis should be given when possible
    - If appropriate, a differential diagnosis should be rendered
    - Significant patient reaction or complication, if applicable

If there may be the need for follow-up or additional studies, based on the outcome of the initial study, these should be indicated by the ordering provider as part of the original order when applicable.

Eight-minute rule for Physical, Occupational and Speech Therapy CPT codes based on 15-minute units:

Providers should not bill for timed services if less than a total of eight minutes is spent with the patient.

- One Unit = 8-22 minutes
- Two Units = 23-37 minutes
- Three Units = 38-52 minutes
- Four Units = 53-67 minutes
- Five Units = 68-82 minutes
- Six Units = 83-97 minutes

Medical Record Documentation Policy

To support quality member care and ensure our members are receiving medically necessary and appropriate care related to the purpose of their visit, it is BCBSND's expectation that providers submit documentation specific to the patient and specific to the individual encounter.

Specific encounter documentation helps ensure that appropriate reimbursement can be determined from the documentation and that reimbursement is not inflated by inappropriate or irrelevant information. It is not expected that every patient would have the same problems, symptoms, or would require the same examination and treatment. Documentation should support the individualized care each BCBSND member received.

BCBSND intends to reimburse providers for medically appropriate and necessary services rendered to BCBSND members that treat the condition or concern for which the member is seeking treatment, and for additional concerns or conditions identified during the visit. Documentation without identifiable and appropriate updates specific to the current visit will not be considered for the purposes of determining the service(s) provided for that visit are medically appropriate.

Evaluation and Management (E/M) Documentation Requirements

Effective January 1, 2021, CPT codes 99202-99215 may be billed based on Medical Decision Making (MDM) or total time for the encounter. The definition of time is minimum time, not typical time, and represents total physician or Qualified Health Practitioner (QHP) time on the Date Of Service (DOS). The time of clinical staff (e.g. nursing staff) cannot be included in total time for the DOS. The use of DOS time must be clearly documented in the record to support time was used to select code. This definition only applies when code selection is based on time and not MDM.

The AMA will continue to use the three MDM sub-components for code assignment. The sub-components have been edited for appropriate code selection. For more information reference the current edition of the CPT manual.

All other E/M Codes

The chief complaint and history for new and established patient E/M's do not need to be re-entered in the medical record if information has already been entered by ancillary staff or the patient /member. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

When documenting the history or exam portion of an E/M service, for an established patient office/outpatient visit, if relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed. The defined list of required elements need not be re-recorded if there is evidence that the practitioner reviewed the previous information and updated it as needed.

All Previous documentation that is reviewed must include the date and time of the visit being reviewed, what information has specifically been reviewed and verified, and what, if anything, has changed per CPT guidelines, for E/M codes other than 99202-99215, established patients are required to meet two of the three key components of history, examination and MDM to determine the level of E/M service billed. BCBSND requires that one of the two levels used to determine the level of service is the MDM component. The documentation of the MDM must be specific to the current encounter.

Amended Medical Records

Late entries, addendums or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of the entry, addendum or correction and is signed by the person

making the addition or change. When a correction is made, the incorrect information should never be removed or deleted from the record. The incorrect information should be noted with a line drawn through it, or other appropriate indication, and the section dated, and signed with a reason for the correction noted.

All medical record documentation must comply with BCBSND policies and support the services and diagnosis submitted on the claim form at the time of the original claim submission to BCBSND. Corrections to the medical record prior to claim submission will be considered when determining the validity of services billed. If changes appear in the record following a request for records, medical review or audit, only the original record will be reviewed when making determinations.

REIMBURSEMENT & BILLING GUIDELINES

Reimbursement

General

BCBSND reimburses participating providers based on the lesser of charges or fee schedule amount. Specific product discounts or contractual arrangements that providers may have with BCBSND are not reflected in the fee schedules. These fee schedules are considered confidential and proprietary and are intended for the exclusive use of BCBSND participating providers. Participating providers may only use or disclose the information for the purpose of practice management, billing activities and other business operations, or to disclose the information to the North Dakota Insurance Commissioner. Any other use or redistribution of these fee schedules without the written consent of BCBSND is prohibited.

CPT and HCPCS codes that are not in the fee schedule are considered to be “by report.” Additional codes not in the fee schedule are manually reviewed and payment is determined on an individual basis.

The existence of a procedure code on the fee schedules is not a guarantee the code is valid or covered. Fee schedules may contain procedure codes that have been replaced by other HCPCS or CPT codes. Edits in BCBSND’s system check for procedure validity and will reject invalid codes. Some codes may represent services for which benefits are not available.

Member Cost-Sharing

Deductibles, coinsurance and copayments are the member’s financial contribution toward all services, also known as out-of-pocket costs. As a participating provider, you have agreed to not waive these amounts. When the charge for an office visit is less than the member’s copayment, providers should collect the actual charge. If you collect any amount above the copayment for covered services, you must refund the member the excess amount collected.

NCCI Edits

BCBSND follows National Correct Coding Initiative (NCCI) edits. Providers may notice that code combinations they previously billed, will now deny as inclusive to another service or line as a

result of this. Prior to contacting Provider Service, we would encourage providers to verify their coding against NCCI edits via the following: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html

Providers must review for correct coding and if the criteria are met for eligibility to bill the code combination, a replacement claim must be submitted.

National Drug Code

A National Drug Code (NDC) is required for medical drug claims. Claims that do not meet this requirement will be denied.

Not Otherwise Specified (NOS) and Not Otherwise Classified (NOC)

All CPT and HCPCS codes that do not have a specific code description (i.e. Unlisted, Not Otherwise Specified (NOS), Not otherwise Classified (NOC), Unclassified, etc. codes) will be rejected. Previously, BCBSND would return these claims with a letter. With the new HMHS claims processing system, these claims will be rejected. This requirement is excluded for anesthesia services, codes 00100-01996.

The required information related to these codes can be submitted in the following manner:

- For electronic claim submission, the information is placed in the SV101-7 of the 2400 service line loop
- For paper claim submission, the information is placed in Box 19 of the CMS-1500 claim form
- Examples of NOS/Unlisted or Unspecified Codes:
  - 83520 (Immunoassay, quantitative, not otherwise specified) – a description of the method or technique would be needed
  - 21499 (Unlisted musculoskeletal procedure, head) – requires a description of the procedure performed
- In order for an accident-related dental claim to be processed under medical coverage, an accident date is required. If the accident date is not provided in the loops and segments listed below, the claim will not process.
  - Loop/Segment/Element for tooth number = 2400 SV101-7
  - Loop/Segment/Element for accident date = 2300 DTP03, with a qualifier of 439 in DTP01

Dental Services Performed by a Dentist or Oral Surgeon

The following services are allowed under Medical when performed by a dentist or oral surgeon and should be submitted on the CMS-1500 claim form.

- Services related to an Accidental Frenotomy/ Frenectomy
- Oral Biopsy
- Oral Lesion Removal
- Oral Abscess Treatment

Professionals in Training

Professionals in training must be working towards and participating in a supervision plan to become a recognized, payable provider by Blue Cross Blue Shield of North Dakota (BCBSND). These professionals must practice under the direct supervision of a provider, as approved by the individual's board who is licensed, registered, or certified by the appropriate state agency and meets the credentialing criteria set forth by BCBSND. Direct supervision means the supervising provider must be present in the office suite and/or on a telehealth visit and immediately available to provide assistance or direction to the professional in training. Services must be billed using the supervising provider's NPI and appropriate modifier when applicable to identify professionals in training who are eligible and must bill under the supervising provider's NPI. Professionals in training who are eligible and must bill under the supervising provider's NPI:

- Licensed Associate Professional Counselor (LAPC)
- Licensed Associate Marriage Family Therapist (LAMFT)
- Graduate Registered Nurse Anesthetists (GRNA)
- Post-doctoral Psychology Resident
- Psychiatry Resident in psychotherapy training under the direct supervision of a psychologist
- Resident Psychiatric Physicians in their 2nd year of training or greater that have met the specific supervision standards through their accrediting body

Professionals in training who are not eligible to bill:

- Resident Physicians
- The attending/supervising physician must either be present while the substantial elements of the history and examination are performed by the resident, or the attending/supervising physician must independently perform them. Billing occurs under the attending/supervising physician's NPI.
- The attending/supervising physician participates in the clinical decision making and formulation of the treatment plan. Documentation by the attending/supervising physician needs to support this information.

Billing for Services Provided to Immediate Family Members

Immediate Family Member is defined as a person who ordinarily resides in a provider's household or who is related to the provider, including but not limited to a provider's parent, sibling, child or spouse, whether such relationship is by blood or exists by law. This applies to providers treating themselves as well.

Health care providers may submit claims for the following types of services provided to immediate family members:

- Diagnostic Radiology (technical component only)
- Diagnostic Lab (technical component only)
- Nuclear Medicine Therapy (technical component only)
- Supplies

Health care providers may not submit claims for the following types of services provided to immediate family members:

- Medical office visits
- Medical hospital visits
- Routine surgery
- Maternity
- Consultations
- Anesthesia
- Assistant at surgery
- Therapy or manipulation services
- Professional component or interpretation of radiology, laboratory or other medical services

FEP does not allow benefits for any services, drugs or supplies provided to the provider's family members, including spouse, parent, child, brother or sister by blood, marriage or adoption.

Vaccination Administration for Pharmacists

Pharmacists who have received the required training and are credentialed and participating with BCBSND are authorized to administer vaccinations to members as appropriate. Proof of valid ND pharmacist license, pharmacist NPI and certificate of immunization training is required to become a credentialed and participating provider with BCBSND. Pharmacist administered vaccinations must be submitted as medical claims using the pharmacist individual NPI as the rendering provider and the pharmacy NPI as the billing provider. Claims received with the pharmacy NPI listed as the rendering provider will be rejected.

Provider-Based Status

Participating providers are reminded that BCBSND does not recognize Medicare's provider-based designation. Services including lab, radiology, chemotherapy and other injections provided to BCBSND members in a clinic or office setting must be billed on a CMS-1500 claim form. The affiliated hospital may not separately bill for any portion of a service provided in the clinic.

Critical Access Hospital Status

Critical Access Hospital (CAH) status is a Medicare designation. According to Medicare's billing guidelines for CAHs, providers are not required to submit outpatient services using HCPCS. However, in situations where BCBSND is the primary payer, all of BCBSND billing and coding guidelines continue to apply. The appropriate HCPCS must be submitted with revenue codes for the claim to process correctly.

Rural Health Clinic

A Rural Health Clinic is a special Medicare designation. BCBSND receives Medicare cross-over claims that are submitted by rural health clinic providers, but that designation and billing should not be used on claims where BCBSND is the primary payer. In other words, there should be no UB-04 claim submitted for services received in a rural health clinic where BCBSND is the primary payer under either the rural health clinic provider number or the acute hospital provider number. These services should be submitted on a CMS-1500 using the provider's individual NPI.

Incident to Billing

BCBSND does not recognize “incident to” billing. Incident to billing is a Medicare billing policy and, as such, it has specific criteria set up for those situations.

Split/Shared Services-FS Modifier

When a service is rendered and split or shared between providers, only one of the providers may bill Blue Cross Blue Shield of North Dakota (BCBSND) for split or shared services. BCBSND will only reimburse one of the billing providers for the services rendered. The provider which performed more than 50% of the time of the visit, or the provider which performed and documented in its entirety either the history, exam, or medical decision-making portion of the note will be the determining factor for reimbursement.

The provider submitting the claim should append the FS (Split or Shared Evaluation and Management Visit) modifier to attest the service was split or shared.

Member-Demanded Services

The use of the GA modifier is allowed on professional and institutional claims, as indicated below:

- GA modifier - Member has requested a non-covered service and has signed an Advance Member Notice form (AMN, also known as a “waiver”), agreeing to pay for the service. The requested service is not medically necessary for their condition. Charges will be denied, as member liable.

Services submitted with the GA modifier will be denied as member liable. Medical information will not be requested or reviewed prior to the denial. BCBSND will conduct routine audits of services billed with these modifiers, requesting chart notes (and signed AMNs, if applicable) to verify appropriate usage. Services billed inappropriately will be reprocessed as provider liable. Further actions may be taken if inappropriate usage continues.

The AMN form can be found on the BCBSND website under Provider Forms and Documents. Please make sure to use the appropriate form. Do not use Medicare’s form or other provider-designed waiver forms. The AMN must specifically identify the non-covered services and procedure codes. General notices will not be accepted.

With the exception of benefit reasons, AMNs cannot be used to collect amounts otherwise not payable, including:

- Medical policy - Clarification: The AMN is to be used when services are not medically necessary. The AMN is not necessary for a Medical Policy that indicates the procedure or service is cosmetic or experimental/investigative in nature as claims will continue to deny as member liable.
- Providers on Corrective Action Plans
- Services provided outside the scope of the provider’s license
- High charges for covered services
- Bundled services
- Items included in a procedure (e.g., surgical trays)

- Multiple procedure discounts
- AMNs cannot be used to collect from members for failure to obtain precertification
- AMNs cannot be required as a condition of providing covered services

This does not apply to FEP.

Surgical Roll-up Methodology

Hospital outpatient claims are billed with Type of Bill (TOB) 131 and are reimbursed on the surgical roll-up methodology.

For specific information regarding surgical roll-up, see the Outpatient Surgical Reimbursement policy, under Policy & Precertification at https://www.bcbsnd.com/providers

Trauma Activation

Trauma activation is included in the rate for the APR-DRG payment and will not be allowed separately on an inpatient claim. Trauma Activation for outpatient services will be reimbursed at a flat rate, which will be dependent upon the level of trauma designation by either the American College of Surgeons or the State of North Dakota.

A trauma activation fee can be billed when activation of the designated trauma team occurs. The activation fee does not replace any emergency room charges the patient may incur. Providers must meet the minimum data element requirements for the North Dakota State Trauma Registry. There must be pre-hospital notification based on field triage or inter-hospital transfer to be eligible for submission of a trauma activation fee. A trauma activation fee is not allowed for patients who arrive without notification.

An additional payment per case will be made based on the trauma level designation. For outpatient services, trauma activation will be reimbursed the lesser of charges or fee schedule amount. The rates are not subject to the mid-tier, rural or western rural adjustment for outpatient services.

Providers must submit the claim with the appropriate trauma level revenue code for their trauma level designation to receive the additional payment. Outpatient claims must have G0390 and a line item service date or the claim will be returned. The following chart identifies the appropriate billing requirements for trauma activation.

Billing for Trauma Activation on UB-04					
	Revenue Code	**Description**	**Units**	**HCPCS**	**Line Item Date of Service**
Outpatient	0681	Level I Trauma	1	G0390	Required
	0682	Level II Trauma	1	G0390	Required
	0683	Level III Trauma	1	G0390	Required
	0684	Level IV Trauma	1	G0390	Required
	0689	Other Trauma Response (Use for Level V trauma)	1	G0390	Required

Waivers and Discounts

Waiver of cost-sharing amounts
Per the Provider Group Participation Agreement, a provider must not waive or reduce any member's cost-sharing amounts, including coinsurance, co-payment and deductible amounts. The provider is expected to bill the member for cost-sharing amounts and non-covered services identified as billable by BCBSND. This policy shall not prohibit the provider from accepting a lesser amount per their hardship and/or collection policies.

Member discounts
BCBSND defines a member discount, for the purpose of this policy, as any promotion or special consideration that reduces the provider's customary charge for covered services.

Participating providers offering member discounts must adhere to the following guidelines:
- The discount must be available to all patients, regardless of whether insurance coverage is involved
- The provider's customary charge submitted to BCBSND must reflect the discounted amount

Description	Amount
Provider's customary charge	$100
Less: Member's discount	$30
Charge billed to BCBSND	$70
BCBSND allowance	$85
Member co-payment	$20
BCBSND payment to provider*	$50
Amount to be collected from member	$20

*BCBSND shall base reimbursement on the lesser of the provider's billed charges or the BCBSND payment system in effect at the time services are provided

Reimbursement Policies & Billing Guidelines

The reimbursement policies are coverage decisions that are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and/or federal law. Any policies contained in the Coding and Reimbursement section do not constitute plan authorization, nor are they an explanation of benefits. Providers should contact BCBSND Provider Service for specific coverage or policy information.

These policies & guidelines can be found by visiting https://www.bcbsnd.com/providers/policies-precertification/reimbursement-policy

Ambulance

An ambulance is a specially designed or equipped vehicle used only for transporting the critically ill or injured to a health care facility. The ambulance service must meet state and local requirements for providing transportation for the sick or injured and must be operated by qualified personnel who are trained in the application of basic life support.

BCBSND may contract with ground ambulance providers, if the provider's headquarters or fully functioning business operations are located within BCBSND's service area.

Requests for or offers to contract with out-of-state air ambulance providers are reviewed on a case-by-case basis. BCBSND may contract with an air ambulance provider, if the air ambulance's patients will be picked up in a location that is within BCBSND's service area based upon the zip code of the point of pickup.

Chiropractic

Maintenance Care

All services performed for a maintenance care visit are non-covered and are benefit exclusions. When submitting a claim for chiropractic maintenance care use HCPCS code S8990 (Physical or manipulative therapy performed for maintenance rather than restoration).

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is defined as items that can withstand repeated use and are primarily used to serve a medical purpose outside of a health care facility. Such items would not be of use to a person in the absence of illness, injury or disease. BCBSND reimburses most DME on a rental or purchase basis.

DME services must be provided:

- While the member is under the care and treatment of a physician or other qualifying health care professional; and
- While the member's health care plan is in effect and the patient is a covered member under the health care plan.

- To determine DME benefits including maximum benefit allowances, contact
  - Provider Services at 800-368-2312
  - Member Services at 844-363-8457

Home Health Services

Home health is care provided by a home health agency to an essentially homebound member in the member's place of residence. The home health agency must be licensed, registered or certified in the state where the services are performed and provided in accordance with the home health agency's scope of licensure as provided by law. The services must be provided on a part-time or intermittent basis, according to a professional healthcare provider's prescribed plan of treatment approved by BCBSND prior to admission to home health care. Benefits are available only if, in the absence of home health care, the member would require inpatient hospital or skilled nursing facility services.

Home health services may include skilled services (physical therapy, occupational therapy, speech therapy and skilled nursing), and home health aide services. A patient must receive a skilled service in order to qualify for a home health aide service.

Long Hour Nursing care is a separate level of service provided by a home health agency when a skilled nursing visit exceeds two hours in length. Examples may include IV infusion greater than two hours requiring constant supervision by a nurse or nursing care to a ventilator-dependent child or adult. When a home care skilled nursing visit is two hours or less, intermittent visit codes should be used.

Billing Guidelines

Precertification is required for all home health visits and long hour nursing care. Nurse visits for the purpose of assessment or for management and evaluation of the patient's care plan are not covered by BCBSND. Therapy visits performed as part of a maintenance program are not covered by BCBSND.

Home Infusion Therapy

Home infusion therapy services include the provision of nutrients, antibiotics, and other drugs and fluids administered intravenously, including all medically appropriate and necessary supplies. A home infusion therapy provider provides these services to members or their families who have been trained in the administration of these services.

Home infusion therapy providers must have a separately signed participation agreement and a separate National Provider Identifier (NPI). A home infusion provider is not the same as a home health agency. Reimbursement is based on the lesser of the provider's billed charges or the payment system in effect at the time services are incurred.

For additional information refer to the fee schedule portal for up to date reimbursement notices.

Inpatient Swing Bed – Hospital Billing

Inpatient services delivered to swing bed patients will be reimbursed an all-inclusive per diem rate. The per diem rate includes all services normally used in a swing bed treatment program, such as room and board, lab, X-ray, all therapies, diagnostic testing, services of social workers, licensed addiction counselors, nurses, physical, occupational and speech therapists and dieticians, etc.

The following services are reimbursable in addition to the swing bed per diem rate:

- Chemotherapy Agents
- Chemotherapy Administration
- Radioisotopes and Related Services
- Customized Prosthetic Devices
- CT Scans
- Cardiac Catheterization
- MRIs
- Radiation Therapy
- Angiography
- Outpatient Surgery
- EPO
- Preventive and Screening Services
- Blood Products
- Blood Storage and Processing
- Complex Medical Equipment (e.g. Specialized beds and mattresses and wound vacs when approved during precertification and submitted on revenue code 0946 or 0947)
- Cardiac Rehab

Note: Reimbursement will be based on the lesser of charges or the outpatient fee schedule amount.

Billing Guidelines

Traditional revenue codes should be used to indicate the type of services provided. Items considered to be separately reimbursable should be billed where the services were rendered.

Example: if the patient has a CT scan in the hospital outpatient setting, the CT scan should be billed on a separate UB-04 outpatient (TOB 13x) claim form under the acute provider number. If the patient receives chemotherapy at the bedside in the swing bed setting, these services should be billed with the appropriate HCPCS code(s) and include all other swing bed services on the same UB-04 claim form under the same swing bed provider number.

HCPCS are required on the separately reimbursable items listed above when submitted on the same claim as all other swing bed services. Reimbursement will be limited to the per diem rate when HCPCS are not submitted.

Therapists, social workers, and dieticians should not bill for services on the CMS-1500 claim form when these services are inherent to the treatment program and delivered during the

inpatient swing bed stay. Psychologists and psychiatrists should bill on the CMS-1500 claim form for services that are medically appropriate and necessary.

Inpatient Transitional Care Unit – Hospital Billing

Inpatient services delivered to Transitional Care Unit (TCU) patients will be reimbursed an all-inclusive per diem rate. The per diem rate includes all services normally used in a TCU treatment program such as room and board, lab, X-ray, all therapies, diagnostic testing, services of social workers, licensed addiction counselors, nurses, physical, occupational and speech therapists and dieticians, etc.

The following services are reimbursable in addition to the TCU per diem rate. Reimbursement will be based on the lesser of charges or the outpatient fee schedule amount.

- Chemotherapy Agents
- Chemotherapy Administration
- Radioisotopes and Related Services
- Customized Prosthetic Devices
- CT Scans
- Cardiac Catheterization
- MRIs
- Radiation Therapy
- Angiography
- Outpatient Surgery
- EPO
- Preventive and Screening Services
- Blood Products
- Blood Storage and Processing
- Complex Medical Equipment (e.g. Specialized beds and mattresses and wound vacs when approved during precertification and submitted on revenue code 0946 or 0947)
- Cardiac Rehab

Billing Guidelines

Traditional revenue codes should be used to indicate the type of services provided. Items considered to be separately reimbursable should be billed where the services were rendered.

Example: if the patient has a CT scan in the hospital outpatient setting, the CT scan should be billed on a separate UB-04 outpatient (TOB 13x) claim form under the tienprovider number. If the patient receives chemotherapy at the bedside in the TCU setting, these services should be billed with the appropriate HCPCS code(s) and include all other TCU services on the same UB-04 claim form under the same TCU provider number.

HCPCS are required on the separately reimbursable items listed above when submitted on the same claim as all other TCU services. Reimbursement will be limited to the per diem rate when HCPCS are not submitted.

Therapists, social workers, and dieticians should not bill for services on the CMS-1500 claim form when these services are inherent to the treatment program and delivered during the

inpatient TCU stay. Psychologists and psychiatrists should bill on the CMS-1500 claim form for services that are medically appropriate and necessary.

All Patient Refined-Diagnosis Related Group (APR-DRG)

Overview

The APR-DRG classification system classifies patients into clinically meaningful groups that account for the severity of illness and risk of mortality. APR-DRG also help to provide an accurate and consistent way to compare provider performance. BCBSND utilizes the APR-DRG classification system for all institutional inpatient acute medical surgical and behavioral health inpatient acute claims.

Coding Elements

The following discharge data elements are used for APR-DRG subclass assignment:

- Principal diagnosis coded in ICD-10-CM
- Principal procedure coded in ICD-10-PCS
- Secondary diagnoses coded in ICD-10-CM
- Secondary procedures coded in ICD-10-PCS
- Age
- Sex
- Birth weight (value or ICD-10-CM code)
- Admit Date
- Discharge Date
- Status of discharge
- Days on mechanical ventilator (value or ICD-10-CM code)

If claims are submitted without all this information, or at least the fields that are appropriate to the claim, the processing of the claim could be delayed or in some cases, denied. APR-DRG payments are based on the date of discharge.

Note: Providers should list any diagnosis code(s) necessary to drive the SOI on a DRG claim within the first 25 diagnosis code fields on the UB-04 Claim Form. Diagnosis codes needed for correct DRG SOI not included in the first 25 diagnosis fields will result in the claim processing at a lesser DRG SOI.

Present on Admission (POA) Indicator

BCBSND requires all acute care hospitals to report Present on Admission (POA) indicators for each diagnosis code on inpatient claims. According to the official POA reporting guidelines, located in Appendix 1 of the ICD-10-CM coding guidelines. “Present on Admission” is defined as present at the time the order for inpatient admission occurs – conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery are considered as Present on Admission.

For additional guidance on the use of the POA indicator, please refer to Appendix 1 of the ICD-10-CM coding guidelines.

Note: POA indicators may affect payment for hospital acquired conditions.

Transfer Cases

Transfers include any inpatient cases with a discharge status of a transfer to another short-term acute care facility (02, 05, 43, 65, 66, 70, 82, 85. 88, 93, 94 and 95). Transfer cases are paid on a per diem basis.

The APR-DRG per diem conversion is calculated as follows:

- Base Rate*APR-DRG weight/Network Average Length of Stay (LOS).
- The transfer per diem payment is calculated as follows:
    - Observed LOS for a transfer case *calculated per diem conversion. Final payment is the lesser of per diem or acute payment.

Example: DRG 53, Severity Level 2

- Regular Case Payment Base Rate ($12,011) * APR Weight (0.6423) = $7,715 Per Diem Payment [Acute Payment $7,715 / Network APR-DRG LOS (2.8 Days)] * Actual Transfer LOS (2 Days) = $5,511
- Lesser of Regular Case Payment (1) or Per Diem Payment (2) = $5,511

Note: LOS is calculated discharge date minus admit date plus one.

Outlier Cases

Outlier payments are designed to pay providers an additional amount, over and above the APR-DRG payment, for those cases that fall outside of pre-established thresholds.

Under the APR-DRG system, outlier payments are based on cost. The formula for determining outlier cases is as follows:

- If (Charge x Overall Hospital Ratio of Cost to Charges (RCC) >Outlier Cost Threshold) then Outlier.

Example: DRG 53, Severity Level 2

- Calculation of Case Cost:
  Facility Charges ($37,500) * Overall Hospital RCC (0.7162) = $26,858
- Outlier Payment:
  Case Cost ($26,858) – Outlier Cost Threshold ($21,808) = $5,050
- APR-DRG Case Rate:
  Case Weight (0.6423) * Base Rate ($12,011) = $7,715
- Final Outlier Case Payment:
  APR-DRG Case Rate ($7,715) + Outlier Payment ($5,050) = $12,765

Billing Guidelines

1. Submit claims on the UB-04 Claim Form with Type of Bill (TOB) 111 (Hospital/Inpatient/Admit through Discharge Date Claim). Claims that are paid based on an APR-DRG are not eligible for interim billing.
2. Hospital APR-DRG payments include reimbursement for all services performed during an entire inpatient admission. Services incurred during an inpatient admission regardless of the place of service are part of the APR-DRG and should not be billed separately.

    - These services include but are not limited to outpatient procedures, diagnostic tests and lab tests.
    - Example: A patient who is an inpatient at Hospital A is brought to Hospital B for a CT scan that is not available at Hospital A. Hospital A submits a bill for the entire inpatient stay including the CT scan. Hospital A receives the entire APR-DRG payment and is responsible for reimbursing Hospital B for the CT scan.

3. Report appropriate ICD-10-CM diagnosis codes in Form Locator (FL) 67, 67 A-Q, 69 and 72 A-C.

    - 67: Principal diagnosis code. The 8th digit of the field (shaded area) is for the POA indicator.
    - 67 A-Q: Secondary diagnosis fields. The 8th digit of the field (shaded area) is for the POA indicator.
    - 69: Admitting diagnosis code.
    - 72 A-C: External cause of injury (ECI) code and POA indicator

4. All acute care hospitals must report the POA indicator in FL 67, 67 A-Q in the shaded area corresponding to the 8th digit. The reporting options for all diagnoses are:

    - Y – Yes: Present at the time of admission
    - N – No: Not present at the time of admission
    - U – No Information in the Record: Documentation is insufficient to determine if condition was present on admission or not.
    - W – Clinically Undetermined: Provider is unable to clinically determine whether condition was present on admission or not.
    - Unreported/Not Used or “1”: Exempt from POA reporting

5. Report ICD-10-PCS procedure codes and date in FL 74 and 74 A-E.
6. Report charges associated with each Revenue Code.

    Note: The revenue codes listed below are not allowed on an inpatient APR-DRG claim. Claims will be returned if one of the following revenue codes is submitted:

    - Rev Code 0273 – Take Home Supplies
    - Rev Code 0274 – Prosthetic/Orthotic Devices
    - Rev Code 029X – Durable Medical Equipment (Other than Rental)

Note: Durable medical equipment items used by the patient during their inpatient stay, such as special beds, are a part of the inpatient payment and should not be billed separately.

- Rev Code 051X – Clinic
- Rev Code 052X – Free Standing Clinic
- Rev Code 053X – Osteopathic Services
- Rev Code 054X – Ambulance
- Rev Code 0912 – Partial Hospitalization

7. Report the appropriate discharge status in FL 17.
8. The Statement Covers Period From date in FL6 (“From” Date) is distinctly different than the Admission Date in FL 12 (“Admit” Date). There are times when these dates may be the same, but there are situations when these dates may be different.

    - The Admit Date is the date that the patient is admitted as an inpatient to the facility. This date must be reported on all inpatient claims. The Statement Covers Period (“From” and “Through” dates) identifies the span of service dates included on the claim. The “From” date should be the earliest date of service on the bill.

9. Day of discharge cannot be counted as a unit of service on the room and board Revenue Code on an inpatient hospital, swing bed or skilled nursing facility claim.
10. If the patient has a leave of absence (LOA) during the inpatient stay, the LOA day(s) must be identified with Revenue Code 018X and units equal to the number of LOA days. The following are a couple of examples on how to count LOA days:

    - If the patient leaves the hospital on Saturday afternoon and returns on Sunday afternoon, there is no LOA as the patient received services on both days.
    - If the patient leaves the hospital on Saturday afternoon and returns on Monday afternoon, one (1) LOA day should be billed.

Enhanced Ambulatory Patient Group (EAPG)

Overview

The EAPG classification methodology is used to explain the amount and type of resources used in a wide range of ambulatory visits. Individual services within the visit are assigned to individual EAPG, which are organized by the EAPG logic to reflect the typical resources expended during the visit. BCBSND utilizes the EAPG classification system for hospital outpatient, ambulatory surgical center, partial psychiatric and partial substance abuse claims. Ambulance, home health and hospice services do not apply to EAPG classification.

Billing Guidelines

1. Submit claims on the UB-04 Claim Form with outpatient TOB 131.
2. EAPG payments are based on visits.
    a. A visit is all related services provided to one patient on one date of service.

   b. BCBSND encourages providers to bill all related outpatient services for the same date of service on one claim.
   c. Providers may bill multiple dates of service on one claim.
   d. Multiple EAPGs are commonly assigned per visit and more than one EAPG may be payable within a visit.
   e. Lessor of charge logic will apply to EAPG claims at the visit level.
3. Report appropriate ICD-10-CM diagnosis codes in FL 67, 67 A-Q, 69 and 72 A-C.
4. Report ICD-10-PCS procedure codes and date in FL 74 and 74 A-E
5. Report charges associated with each Revenue Code and CPT or HCPCS code as appropriate.

Significant Procedure Consolidation

When a patient has multiple significant procedures, some of the significant procedures may require minimal additional time or resources. Significant procedure consolidation refers to the collapsing of multiple related significant procedure EAPGs into a single EAPG for the purpose of determining payment.

Same Significant Procedure Consolidation

Same significant procedure consolidation will occur when multiple occurrences of the same significant procedure EAPG are present on a claim. The highest weighted significant procedure EAPG will be paid in full and any subsequent occurrences of that same significant procedure EAPG will be consolidated and receive no payment. BCBSND applies Same Significant Procedure (SSP) for Significant Procedure type (2) and Diagnostic type (25).

Ancillary Packaging

Certain ancillary services will package into the EAPG rate for a significant procedure or medical visit. The ancillary packaging list can be found with the EAPG fee schedule in the online fee schedule portal.

Ancillary Discounting

When multiple occurrences of the same ancillary EAPG are present on a claim, the additional ancillary EAPGs are discounted at 50%.

CARE COORDINATION

Case Management

BCBSND recognizes the emotional impacts of serious illness. Through the voluntary Case Management program, BCBSND wants to provide options of effective and feasible alternatives to members. This program is available at no additional cost to the member. BCBSND realizes when a member meets the optimal level of wellness and functional capability, everyone benefits: the members are served along with their support systems, the health care delivery systems and various reimbursement sources.

Care Coordinators consist of Registered Nurses and Licensed Social Workers trained in the following areas:

- Motivational Interviewing
- Crucial Conversations
- Case Management and Utilization Management

Member assessments include:

- A comprehensive health screening
- Screening for depression and anxiety
- Assessment of Member's Health Engagement
- Medication reconciliation

Care Coordination Interventions include:

- Goal setting with members to achieve optimal health outcomes
- Motivational Interviewing to assess barriers to change
- Assessment of Member Engagement into their health
- Providing education regarding health risks and needs assessment
- Collaboration/Referral to Patient Centered Medical Home/Primary Care Provider
- Transition of care planning for complex cases
- Coordination of local, regional and nationwide healthcare services
- Ongoing case management for complex and chronic cases
- Referrals to Disease Management for rare and complex disease management
- Assist members in making informed healthcare decisions
- Connect the members to the right resources within BCBSND to help them understand their benefits

A member or their authorized representative must consent and agree to participate in the Case Management program. Enrollment in Case Management is voluntary, at no additional cost to the member. A referral to the program is required and is initiated by the individual member, their authorized representative or their health care provider. To initiate a referral to Case Management, contact BCBSND at 800-336-2488.

Prenatal Plus

For those expecting a baby, it's an exciting time. Moms-to-be who know more about having a baby can make smart choices. Our Prenatal Plus Program can help. This maternity management program is here to answer questions and provide support during a member's pregnancy and delivery. Members can work one-on-one with a nurse case manager throughout their pregnancy and after the delivery to answer any questions and help them get the care and services they need.

There is no additional cost to be part of the Prenatal Plus Program, and it is strictly confidential. Moms-to-be receive the following:

- Prenatal care advice
- Guidelines for healthy lifestyle and pregnancy

- Help in preventing preterm labor
- Information on taking folic acid
- Help to quit smoking during pregnancy
- Education on the last weeks of pregnancy
- A checklist of what to take to the hospital
- Information on post-partum depression
- Educational content on breastfeeding
- Information about caring for a newborn

Enrollment

Moms-to-be can sign up at any time while pregnant. Members can sign up as soon as they know they are pregnant. It's the best way to ensure moms-to-be stay as healthy as they can with the assistance of their health care team. Members can call BCBSND at 800-342-4718 or enroll online.

Disease Management

BCBSND's complex, chronic and rare disease management program is a system of coordinated care interventions and member communications for members with rare and complex diseases.

Conditions managed by include:

- Seizure Disorders
- Multiple Sclerosis
- Systemic Lupus Erythematosus
- Hemophilia Dermatomyositis
- Chronic Inflammatory Demyelinating
- Polyradiculoneuropathy
- Crohn's Disease
- Ulcerative Colitis
- Polymyositis
- Amyotrophic Lateral Sclerosis
- Rheumatoid Arthritis
- Cystic Fibrosis
- Scleroderma
- Parkinson's Disease
- Myasthenia Gravis

This program is included at no additional cost for members with these plans:

- Fully insured group insurance
- Self-funded group insurance
- Federal Employee Program (referral to Accordant Health to offer this service)

How It Works

Nurse case managers work individually with members and their physicians to address the unique health care needs associated with high-cost, complex conditions. The nurses:

- Teach effective self-management techniques
- Help providers educate patients
- Promote adherence to treatment plans

In addition, members receive, condition-specific information and an extensive archive of health resources.

Utilization Management Program

Utilization Management (UM) processes are designed to evaluate the medical necessity and appropriateness of services before a member receives treatment.

The authorization process ensures that members receive the highest level of benefits to which they are entitled and the most appropriate setting and level of care for a given medical condition are provided. A BCBSND clinical staff person reviews all pertinent information submitted by providers, then applies defined criteria to determine if a service is medically appropriate. If the information received from the provider varies from the defined criteria, clinical staff seeks review from a BCBSND medical director/pharmacist, as appropriate.

Services Requiring Precertification

Members must obtain precertification before benefits are available for certain services. The BCBSND provider is responsible for all precertification requirements. Services not precertified could be denied.

Visit https://www.bcbsnd.com/providers/policies-precertification/precertification-overview for the list of services and procedures that require precertification.

The following guidelines apply when submitting a precertification:

- Submit requests through the Availity Essentials provider portal at https://www.availity.com.
- Precertifications do not guarantee payment of benefits.
- Services must be medically appropriate and necessary and are subject to conditions, limitations and exclusions of the member's benefit plan.
- Precertification is not required for emergency admissions or post-stabilization care.

Notification Responsibility

A member seeking services from a participating health care provider requiring either Prior Approval or Precertification grants to that health care provider authority to act on behalf of the member as the Member's Authorized Representative. As an Authorized Representative, the health care provider assumes responsibility to act on behalf of the member in pursuing a Claim for Benefits or appeal of an adverse benefit determination from a Claim for Benefits. The member agrees that all information and notifications related to the Claim for Benefits requiring

Prior Approval or Precertification is to be directed solely to the Authorized Representative unless the member specifically requests that any notices or information also, be delivered to the member.

To request Precertification, the member or the member's health care provider, on the member's behalf, must notify BCBSND of the member's intent to receive services. The member's health care provider must provide the necessary information to establish the requested services are Medically Appropriate and Necessary. Submission of Authorizations should be done through Availity Essentials. More information on Availity Essentials Authorization requests can be found on the www.bcbsnd.com webpage https://www.bcbsnd.com/providers/news-resources/availity-essentials

Providers agree to abide by the following UM Program requirements in accordance with the terms of the Agreement and the member's benefit plan. Providers agree to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

Precertification & Concurrent Review/Discharge Planning

Clinicians (Registered Nurses and Licensed Independent Clinical Social Workers) complete initial reviews for the services that require precertification in accordance with established clinical criteria. Please use this link www.bcbsnd.com/web/providers/precertification to see the Services/Procedures requiring precertification.

No precertification is required when BCBSND is secondary to other insurance, unless other insurance benefits have been exhausted or care is non-covered. No precertification is required for maternity admissions that result in delivery. This list does not apply to FEP.

Concurrent review is required for those services listed in the link above, extending beyond the initial precertification period, to ensure that ongoing treatment is appropriate and includes discharge planning.

Working in conjunction with the member and their providers, BCBSND's staff supports discharge planning by providing information on benefits available for those services determined to be medically appropriate and necessary for the member's continued care and treatment.

Outpatient services authorized within a specified time frame (i.e. January 1 – January 10) are authorized during that time period only. Unused days due to weather, closure or sickness will not be extended past the approved date frame. Concurrent requests for additional days will be reviewed for medical necessity and appropriateness.

As a reminder, this process is as follows:

To request Precertification, providers should use one of the following forms found on the BCBSND website (www.bcbsnd.com/web/providers/forms) under Precertification:

- Inpatient Authorization Request
- Outpatient Authorization Request
- ABA Service for Autism Spectrum Disorder Request
- APDS, CGM, Insulin Pump Supplement (also requires the Outpatient Authorization Request)

Procedure for submitting a precertification request to BCBSND:

1. Complete the appropriate Precertification Request form
2. Print a copy
3. Save a copy for your records (electronic or hard copy)
4. Sent to BCBSND - follow instructions on the form

    a. Fax to 701-277-2971. **Note:** this fax line is used exclusively for the Utilization Management platform. Please use this fax number for Precertification Requests ONLY.

    OR

    b. Mail to:
    4510 13th Ave. S.
    ATTN: Utilization Management
    Fargo, ND 58121

5. Once a decision has been made, BCBSND will send a fax notification of the determination to the fax number listed for the requesting provider on the Authorization Request form which will be followed by a letter.

Determination timeliness for initial determinations range up to 72 hours for urgent care or up to 15 days for non-urgent care. These timeframes may be extended when additional medical information is needed to complete the review or in extenuating circumstances.

Retrospective Utilization Management

Retrospective UM is designed to review post service requests in accordance with the member's benefit plan. Medical records and pertinent information regarding the member's care will be reviewed (with input by peer clinical reviewers when necessary) against available benefits and to determine the level of coverage for the service. This review may consider such factors as the Medical Necessity of services provided, whether the claim involves cosmetic or experimental/ investigative procedures, or coverage for new technology treatment. Up to 30 days is allowed for medical necessity review of Retrospective requests.

Peer to Peer Process

The peer to peer process is an opportunity for the requesting/ordering provider to have a one on one conversation with a peer reviewer, when a service has been denied as not medically necessary. The purpose is to further explain the adverse determination - principal reason, clinical rationale, and components of specific medical policy. The denial will not be over-turned as a result of the peer to peer conversation. When the provider has received additional clarification, they may either accept the adverse determination or proceed with a formal appeal. If the original BCBSND peer reviewer is not available, an alternate peer reviewer is made available.

Health care providers may contact BCBSND Provider Service to request a Peer to Peer conversation, providing their contact telephone number and available times to be reached. A peer clinical reviewer will contact the health care provider, making 2 attempts within 3 business

days or as scheduling a formal appointment within 3 business days of receiving the request. If these attempts are unsuccessful and the provider remains unavailable, the peer to peer conversation availability has assumed to be met.

Failure to Comply with Utilization Management Requirements

The Plan may apply monetary penalties such as a reduction in payment, as a result of provider's failure to obtain Pre-service Review on specified outpatient services.

Authorized (Network) Referrals

At the time of enrollment, a Subscriber will be asked to affiliate with a Network. This affiliation process requires a Subscriber to designate a Network that will provide future health care services to the member(s). Once a Network is selected, any services a member receives must be provided within the selected Network to be eligible for benefits at the in-network level.

A member may choose to receive services outside the Network without an Authorized Referral; however, these Covered Services shall be reimbursed at the out-of-network level. If a level or type of service is not available within the selected Network, an Authorized Referral is required to be eligible for benefits at the in-network level.

Network products requiring referrals include the following:

- BlueChoice
- SelectChoice

Referral Guidelines

To ensure accurate and timely claims processing, the Network shall be responsible for all referrals required outside the Network. The following guidelines apply when submitting a referral:

- The Network shall communicate all Authorized Referrals to BCBSND using the Availity Essentials provider portal. To submit an electronic referral request utilize the instructions on the BCBSND Availity Essentials webpage https://www.bcbsnd.com/providers/news-resources/availity-essentials
- Paper submissions will no longer be accepted.
- It is the responsibility of the Network to notify the member of the referral status in a timely manner. Members calling in for details on specific referral requests will be directed to contact their provider.
- Authorization of a Referral: Authorized Referrals shall be for services Medically Appropriate and Necessary and not available within the Subscriber's Network.
- Denial of Referral Requests: Denied Referrals are determined by the Network. The Network may choose to deny the member's request for a referral based on situations such as, but not limited to, the availability of in-network options. Provider or member convenience or preference is not a valid reason for a referral.

As a reminder, it is the requesting provider's responsibility to notify the member of the referral status, including its approval or denial. Members calling in for details on specific referral requests will be directed to contact their provider.

Emergency Services

Emergency services will be reimbursed at the in-network level and referrals are not required.

Levels of Payment

Covered Services related to an Authorized Referral, including, but not limited to anesthesia, surgical assistant, X-ray and pathology, qualify for payment at the in-network level.

An Authorized Referral does not guarantee payment of benefits. Benefits for services received as a result of an Authorized Referral are subject to the conditions, limitations and exclusions of the Subscriber's Benefit Plan. Benefit payment will be denied if the member is not covered under this Benefit Plan on the date the services are provided.

Medical Records

Providers should maintain current, organized, well-documented medical records to facilitate communication, coordination and continuity of care. Records should document all care provided to members. To ensure timely distribution and review of submitted medical records, the submission should include a copy of the medical record request letter from BCBSND. If you are unable to locate your Medical Records Request letter when mailing the records to BCBSND, use the Medical Records Submission Form. Access the form at https://www.bcbsnd.com/providers/news-resources/forms-documents, under the Claims Processing section. When using this form, be sure to include the claim number that the records pertain to.

BlueAlliance

BlueAlliance is a value-based program that supports the provider community in our collective efforts to deliver a sustainable, meaningful and reliable health care experience for our members. It's built on four principles:

Members come first
Because our members are at the center of all we do, the patient-centered medical home (PCMH) is the foundation of BlueAlliance. Using meaningful data, their caregivers can focus on providing the right care, at the right time, at the right place and by the right health care provider.

Deeper partnerships with providers
Through actionable health intelligence, we're adding more value to provider relationships. Where sharing data was once only a path to paying claims, BCBSND now uses data for predictive analytics to influence care delivery for population health management and value-based programs. We're sharing that intelligence with participating providers to guide decision making.

Pay providers for outcomes
BlueAlliance allows the gradual transition from a fee-for-service contracting model to one that pays for quality of care metrics and success in patient outcomes. The program leverages a flexible mix of payment arrangements to accommodate the wide range of providers in our network (rural to urban, small to large, integrated or independent).

Address key cost drivers
BlueAlliance provides information that allows us to collaborate on addressing key cost drivers so together we can ensure an affordable, sustainable health care system in the future.

Pharmacy Management

The Pharmacy Management department strives to ensure that members receive the highest quality pharmaceutical care that is medically appropriate and cost-effective. This is achieved, in part, by maintaining a high-quality pharmacy network and a clinically sound drug formulary and utilization management program.

Pharmacy Network

BCBSND contracts, through its pharmacy benefit manager, with approximately 60,000 pharmacies nationwide. Members and providers can find a conveniently located pharmacy at www.BCBSND.com/manage-my-benefits/pharmacy-listings.

Drug Formulary

A Drug Formulary is a list of preferred prescription drugs chosen by the BCBSND Pharmacy and Therapeutics Committee on the basis of quality and cost-effectiveness. Drugs are selected for the formulary based on safety, efficacy, side effects, ease of use, potential for interactions and cost-effectiveness. Prescribing formulary products provides members with the most cost-effective drug therapy offered through the prescription drug program. The Drug Formulary is available through e-prescribing software and the company's website at www.BCBSND.com/manage-my-benefits/pharmacy-listings.

Utilization Management Programs

BCBSND medication Utilization Management (UM) programs help ensure members achieve the best health outcomes. UM programs provide guidance to members, pharmacists, and prescribers on the appropriate use of medications, so members receive the safest, most effective and cost-efficient medication therapy. The two most common UM programs are quantity limits and precertification. A list of medications requiring precertification or subject to dispensing quantity limits (Restricted-Use Drugs) is available through the company's website at www.BCBSND.com/manage-my-benefits/pharmacy-listings.

Medical Policy

BCBSND medical policies are available at:
www.BCBSND.com/web/providers/medical-policy-disclaimer

The medical policies are developed under guidance of the Internal Medical Policy Committee, which is scheduled to meet bi-monthly. The Committee is composed of BCBSND clinical and coding staff with medical policy accountability. The Committee provides a formal internal review for consensus, awareness and implementation throughout the company.

The purpose of having a distinct process for the development and maintenance of clinical review criteria (commercial and internal) and medical policy is:

- To have reliable research performed before establishment of a policy
- To promote credibility to criteria developed internally
- To ensure criteria and medical policy used is up to date and acceptable to practitioners
- To have an assessment tool by which commercially available criteria can be compared
- To maintain quality of criteria utilized by the corporation

Please note that the medical policies located in HealthCare News may be outdated and replaced by subsequent medical policy determinations, or more updated medical policies appearing online.

Retired Medical Policy

Policies may be retired for a number of reasons, including but not limited to the following:

- The technology has become obsolete/discarded;
- The technology has become standard of care and details about its use are well-known;
- The costs of implementing the policy are too great;
- The issue may be dealt with through other mechanisms, e.g., payment.

Draft Medical Policy

BCBSND strives to develop medical policies in an open, collaborative manner with providers. BCBSND invites you to submit comments during the development phase of BCBSND medical policies. We especially value comments referencing an evidence-based evaluation process. Draft medical policy can be found at www.BCBSND.com/web/providers/draft-medical-policy.

Mail comments to:
Blue Cross Blue Shield of North Dakota
Health Network Innovation
4510 13th Ave. S.
Fargo, ND 58121

Notification of a draft policy will be done via HealthCare News. This is the same way providers are notified when a policy is new, or revised.

Medical Necessity Criteria

Medical necessity criteria are used to conduct clinical determinations. BCBSND reviews treatment for medical necessity in accordance with the below definition:

MEDICALLY APPROPRIATE AND NECESSARY - services, supplies or treatments provided by Health Care Provider to treat an illness or injury that satisfy all the following criteria as determined by BCBSND:

- The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the member's illness or injury.
- The services, supplies or treatments are consistent with professionally recognized standards of health care; and the services, supplies or treatments do not involve costs that are excessive in comparison to alternative services that would be effective for diagnosis and treatment of the member's illness or injury.
- The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of the member's illness or injury.
- The services, supplies or treatments are consistent with professionally recognized standards of health care; and the services, supplies or treatments do not involve costs that are excessive in comparison to alternative services that would be effective for diagnosis and treatment of the member's illness or injury.

BCBSND uses the InterQual Criteria and BCBSND Medical Policy available online at https://www.bcbsnd.com/providers/policies-precertification to assist clinicians in making informed decisions. Other evidence-based resources may be used in addition to the above when determining medical necessity.

Technology Assessment Evaluation Criteria

Providers may submit requests for BCBSND to review new technology for a coverage determination or development of a medical policy. The form can be found by visiting https://www.bcbsnd.com/providers/news-resources/forms-documents under New Technology. BCBSND uses the following five criteria for evaluation of new technology:

- The technology must have final approval from the appropriate government regulatory bodies.
    - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the technology.
    - Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.
    - The indications for which the technology is approved need not be the same as those which BCBSND is evaluating.

- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
    - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
    - The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition, there should also be evidence, or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
    - Opinions and evaluations by national medical associations, consensus panels, or other technology assessment evaluation bodies are evaluated according to the scientific quality of supporting evidence and rationale.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as or more than established alternatives.
- The improvement must be attainable outside the investigational settings. When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy criteria #3 and #4.

QUALITY MANAGEMENT

The Quality Management Department provides for planned, systematic activities and processes to monitor and evaluate patient care and services for the primary purpose of assisting providers to improve quality. Quality management includes activities to identify and resolve issues that affect the quality of patient care and services and measure improvements in medical outcomes as a result of treatments provided.

If you have a concern with the quality of patient care or services, please contact: QualityManagement@bcbsnd.com.

Patient Experience Surveys

A Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is administered on an annual basis to identify opportunities for improvement in patient care and services. A separate Qualified Health Plan (QHP) Enrollee Experience Survey is also administered annually to members on the Health Insurance Marketplace by a CMS approved NCQA certified CAHPS vendor according to CMS requirements.

Member satisfaction is evaluated for services provided by BCBSND, hospitals, individual physicians and other providers. Survey results are analyzed and reviewed for trends and opportunities for improvement.

Quality Measures

BCBSND measures, analyzes, and reports results of quality measures. Quality measures include but are not limited to the Quality Rating System measures for the Health Insurance Marketplace and commercial members, Healthcare Effectiveness Data and Information Set (HEDIS) measures for FEP members.

Data is collected though claims, medical record review, and the CAHPS and QHP Enrollee Experience surveys and will be reported in accordance with NCQA, URAC, CHIPRA, and Blue Cross Blue Shield Association (BCBSA) requirements. Results of the measures are benchmarked against established goals and monitored for any trends.

Blue Distinction Specialty Care

The Blue Distinction Specialty Care Program is a program through the BCBSA. It is a national designation program that recognizes health care facilities that demonstrate expertise in delivering quality care safely, effectively, and cost-efficiently.

There are two levels of designation:

- Blue Distinction Centers: Health care facilities recognized for their expertise in delivering specialty care.
- Blue Distinction Centers+: Health care facilities recognized for their expertise in delivering specialty care and cost efficiency. Healthcare facilities must meet nationally established, objective quality measures for the Blue Distinction Center designation in order to be considered for the Blue Distinction Centers+ designation.

Specialty care programs available include: Bariatric Surgery, Cardiac Care, Knee and Hip Replacement, Maternity Care, Spine Surgery, Fertility Care, Substance Use Treatment and Recovery and Transplants.

Member Grievance

A grievance is a written or verbal complaint submitted by or on behalf of a covered member and/or the member's Authorized Representative that involves one of the following:

- A quality of care grievance is a complaint related to the quality of health care services by a Physician or Health Care Provider.
- A quality of service grievance is a complaint related to the non-clinical services received by a member that may include but is not limited to complaints regarding access to care, waiting times, claims payment or reimbursement for health care services.
- An administrative grievance is any complaint involving the terms of coverage and plan services administered by BCBSND.
- A health utilization management grievance is any complaint related to the precertification/ prior approval process that may include timeliness of determinations and determination letters not received.
- A provider grievance is a complaint in which the member or the member's Parent requests to change providers.

The member and/or the member's Authorized Representative can file a grievance or receive assistance with filing and/or completing a grievance by contacting Member Services using the number on the back of their ID card or at the following address:

Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121

Grievances may be filed verbally or in writing no later than 180 days after the incident. The member and/or the member's Authorized Representative will receive a response within 30 days.

SPECIAL INVESTIGATIONS UNIT (SIU)

BCBSND established the Special Investigations Unit (SIU) department to ensure that claims paid by BCBSND are free from coding or billing errors, and services provided were medically appropriate, necessary and delivered in accordance with the member's benefit plan, accepted medical practice standards, and BCBSND policies. These processes ensure fair and equitable coding and billing practices as well as protect our members. The SIU department works with providers to correct any errors identified.

Objectives

- Perform audits of:
  - Claims identified as being at risk for inaccurate coding or billing.
  - Inpatient claims reimbursed by Diagnosis Related Groups (DRG) to ensure accurate assignment.
  - Claims at risk of not meeting medical policy guidelines.
  - Random providers and facilities.
- Other objectives:
  - Review claims and corresponding medical records for appropriate coding based on nationally accepted coding guidelines, national coverage standards and BCBSND policy.
  - Identify incorrect code assignments that affect payment to the provider.
  - Inform providers of review findings.
  - Identify and monitor coding variations between facilities and providers.
  - Provide education based on findings to promote consistency in code utilization among providers.

Provider Audit and SIU Process

For claims reimbursed by DRG, please see the DRG Coding Audit section.

Audit Process

- Claims are analyzed for appropriate submission and payment.
- Claims identified as potentially at risk of inappropriate submission, coding, or payment are selected for additional review.
- Medical records and any additional information, if required, are requested from the provider or facility via certified letter with an identified due date.
    - If the requested information is not received by the due date, all claims associated with the requested information are denied and not eligible for reconsideration.
- Claims, medical records and other supplied information are reviewed by a coding professional for compliance with CPT, HCPCS, ICD--CM and ICD-PCS, CPT Assistant, Coding Clinic, and BCBSND policy, as well as other nationally accepted coding guidelines, and BCBSND policy.
- If applicable, the claim may be reviewed for medical necessity by an appropriate medical professional.
- Results of audit findings are communicated via a letter to the provider and/or other designated contact, or via a written memorandum provided during an onsite visit. The process for correcting any identified errors is outlined in the letter or memorandum. The provider will have 30 days to correct any identified errors (If applicable), or to request a reconsideration.

Note: Should a provider fail to respond within the 30-day timeframe, in fairness to all providers, the provider has waived any opportunity for a reconsideration or adjustment.

Reconsideration Process

If the provider disagrees with any findings, they may request a reconsideration. The reconsideration process is an opportunity for providers to request reconsideration of findings made as a result of an original audit conducted by SIU and Provider Audit. This process applies only to findings communicated by the SIU and Provider Audit department.

The provider must submit a written request. This request must include any additional information, any medical records not previously supplied, and the rationale for the request within the deadline communicated in the notification of audit findings. Please send the request to:

Manager SIU and Provider Audit
Blue Cross Blue Shield of North Dakota
4510 13th Ave. S.
Fargo, ND 58121

The request will be reviewed by a different coding or medical professional. BCBSND will respond to the provider within 45 days of the receipt date of the request with a determination unless otherwise communicated. This is the final level of reconsideration or review. No further adjustment or reconsideration of the claims will occur.

Self-Audit

Audit Processes

If during an audit significant errors are identified, a provider may be required to complete a self-audit. If required:

- The provider will be provided with a list of all claims subject to the self-audit.
- The provider will have the opportunity to review their medical record documentation.
    - If the provider finds upon their review that the documentation supports the service billed, they must supply the supporting documentation in compliance with the instructions in the letter or memorandum.
    - If, upon review, it is identified that a more appropriate code should have been billed; the provider will send the corrected claim information and submit this information along with all supporting documentation.
    - If it is determined the service(s) should not have been billed, the provider may submit corrected information indicating such or not respond. All claims without supporting documentation supplied by the deadline will be denied as indicated in the communication.
- Submitted documentation will be reviewed by a coding or medical professional. This is considered a reconsideration.
    - Claims found to be appropriately supported by the documentation will remain paid.
    - Claims submitted for correction will be corrected if the documentation supports the requested change.
    - Any claims or correction requests found not supported by documentation supplied will be denied and this will be communicated back to the provider. No further opportunity for reconsideration or adjustment is available.
- Claims with no documentation supplied will be denied. No further opportunity for review of records not initially submitted is available.

DRG Coding Audit

Audit Processes

- Inpatient claims are extracted in an edit process based on the quarter the claims were paid.
- The Reimbursement Coding Coordinator selects those claims that are identified as having one or more edits for review.

- The Reimbursement Coding Coordinator follows appropriate ICD-10 coding conventions and guidelines, UHDDS guidelines, Coding Clinic, and BCBSND policy when conducting coding reviews.
- The BCBSND Medical Directors provide input for cases where insufficient or conflicting medical record documentation may exist.
- Results of review findings are provided to the facility's Medical Record Department or other designated contact on a quarterly basis. BCBSND provides Individual case summaries and the rationale used in making a change recommendation when disagreement with the original claim submission occurs.
- The providers have 45 days following this notification to request reconsiderations or if in agreement, request an adjustment.
- The DRG Reconsideration Process is available to providers and consists of two levels of reconsideration.

DRG Audit Reconsideration Process

The reconsideration process is a process for providers to request reconsideration on claim decisions made as a result of a DRG Coding Audit. This process applies only to the DRG Coding Audits.

First Level of Reconsideration

The provider must send a written request via certified mail. This request must include any additional information, any medical records not previously supplied, and the rationale for the request within 45 days of certified receipt date of the DRG notification letter.

The request will be reviewed by a coding professional. If following this review, the conclusion remains adverse, a medical doctor will review the case and make the final determination.

BCBSND will respond to the provider within 45 days of the certified receipt date of the request with a determination. This level of reconsideration will determine if medical documentation and treatment provided supports the rationale for allowing the claim as originally submitted.

If the attending physician and/or Medical Director wishes to discuss a claim with the BCBSND Medical Director, the appropriate time is after the first level reconsideration has taken place and the provider has received the response letter from BCBSND. After an inquiry, if a disagreement remains regarding the proposed determination, the provider may request reconsideration to the second level.

Second Level of Reconsideration

The provider must send a written request via certified mail with any additional information within 45 days of the certified receipt date of BCBSND first level reconsideration response.

An external physician consultant, with the same or similar specialty as the health care provider, will review the request. BCBSND will respond to the provider with a determination within 45 days of certified receipt date of the request. This is the final level of reconsideration for issues related to DRG Coding Audit with BCBSND.

Independent External Review

A health care provider may request an Independent external review as outlined in the Appeals section of this manual. This external review may be requested only after exhausting the above reconsideration processes.

Rebilling Process

DRG Coding Review

The provider must submit a claim adjustment with the appropriate recommended changes as indicated in the final determination within 45 days from receipt. The provider should not submit a new claim but request a claim adjustment. The provider should attach a copy of the notification letter to the claim being adjusted. If a claim adjustment is not received within 45 days from date of certified notification, the claim will be denied

APPEALS

Overview

This section identifies the inquiry and appeals definitions, as well as the different types of each. The inquiry and appeals process does not include questions related to fee schedule amounts, reimbursement or the Special Investigations Unit (SIU) and Provider Audit functions.

Provider Inquiry and Appeal Process

Inquiry

An inquiry is defined as a provider initiating a request to BCBSND, on behalf of the member, for prior approval, precertification or to research a benefit or payment.

The following table identifies the types of inquiries and response time frames that apply to each:

Type of Inquiry	Time Frame for BCBSND to Respond
Pre-Service Claim for Benefits	Written response within 30 calendar days
Emergency Claim for Benefits	Verbal response within 72 hours, followed by a written response within 3 calendar days
Retrospective Review Claim for Benefits	Written response within 30 calendar days
Post-Service Claim for Benefits	Written response within 60 calendar days

Pre-Service Claim for Benefits Inquiry

A pre-service claim for benefits inquiry is a request, either verbal or written, that is subject to a member obtaining approval in advance of obtaining the benefit or service.

There are two types of pre-service inquiry:

- Pre-service claim for benefits
- Emergency claim for benefits

An emergency claim for benefits inquiry is when the timeframe for the pre-service claim for benefits inquiry would seriously jeopardize the member's life, health or ability to regain maximum function. If the services in question meet the definition of emergency medical condition, the inquiry will be considered emergent.

An emergency medical condition is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Retrospective Review Claim for Benefits Inquiry

A retrospective review claim for benefits inquiry is defined as a request, either verbal or written, for a medical review of services that is subject to a member obtaining approval in advance of obtaining the benefit or service — but advance approval was not obtained before services were provided to the member. Determinations regarding retrospective review claim for benefits are based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

The provider is responsible for providing BCBSND with a retrospective review claim for benefits within 180 days after the date the benefits or services offered under their benefit plan were incurred. BCBSND will provide a written response to the provider with the outcome of the review within 30 calendar days of receipt of the request. Any inquiry received after 180 days will be returned to the provider without review.

Post-Service Claim for Benefits Inquiry

A post-service claim for benefits inquiry is defined as a written request expressing disagreement with a claim that was processed correctly according to the member's benefit plan that was not subject to a member obtaining approval in advance of obtaining the benefit or service. A provider has 180 days from the date the claim was processed to make such an inquiry. BCBSND will respond to these inquiries within 60 calendar days, upon receipt of all relevant information. Any inquiry received after 180 days will be returned to the provider without review.

Note: The inquiry determination will be provided in writing, by telephone or through the provider remittance.

Appeal

An appeal is a provider expressing disagreement with an inquiry determination and requesting a change in that decision. The types of appeals include:

- Pre-service claim for benefits appeals
- Retrospective review claim for benefits appeals
- Post-service claim for benefits appeals

Pre-service and retrospective review appeals can be either verbal or written; however, post-service appeals must be written. Verbal inquiries seeking to appeal an action will be treated as an appeal and must be followed by a written, signed appeal unless the member is requesting an expedited appeal. Verbal pre-service claim for benefits standard appeals must be followed with a written, signed appeal.

Pre-service claim for benefits appeals occur before the service in question is rendered. A pre-service claim for benefits appeal is further categorized as standard or emergency.

Retrospective review claim for benefits appeals and post-service claim for benefits appeals occur after the service has been provided.

The table below identifies the types of appeals and response time frames that apply to each:

Type of Appeal	Time Frame for BCBSND to Respond
Pre-Service Claim for Benefits	Written response within 30 calendar days
Retrospective Review Claim for Benefits	Written response within 30 calendar days
Post-Service Claim for Benefits	Written response within 60 calendar days

Appeal Process

A provider may submit written comments, documents and records, or other documents relating to the case to appeal an inquiry determination. The appeal must be received within 180 days from the date BCBSND notifies the provider of the inquiry determination. The provider must specifically state the nature of the appeal and include all supporting information and rationale for overturning the inquiry determination. Any appeal received after 180 days will be returned to the provider without review.

BCBSND will take all the information into account during the appeal process without regard to whether the information was submitted or considered in the initial consideration of the case.

A BCBSND Medical Director or Medical Consultant who was not involved in the original inquiry determination will review the appeal. The reviewer will be board certified in the same or similar specialty as the provider who typically manages the medical condition appealed and will not be the individual who made the original non-certification, or an individual who reports to the person who made the original non-certification.

BCBSND will implement the decision of the appeal if the initial denial is overturned and respond with a written notice of the final determination, including an explanation of the reason for the determination within the time frames shown above.

Federal Employee Plan Disputed Claims Process/Guidelines

Providers cannot appeal a FEP claim denial unless appealing on the member's behalf with signed consent from the member.

Effective June 14, 2021 Blue Cross Blue Shield of North Dakota (BCBSND) only accepts an FEP Advanced Benefit Determination (ABD) request for a service, procedure or Durable Medical Equipment (DME), if the charge is $5,000.00 or greater. The FEP ABD allows providers to contact the FEP customer contact center at the Local Plan to request information pertaining to a non-urgent service, procedure or a piece of DME, for which the contract does not require precertification or prior approval for. If the ABD request is accepted and reviewed, a notification letter will be sent to the provider. For any questions, please call 1-800-548-4026.

For proper protocol on FEP post-service appeals, please see the member's instructions below, para-phrased from the member's Service Benefit Plan brochure:

Ask BCBSND in writing to reconsider the initial decision. A member or provider must:

- Write to BCBSND within six months from the date of BCBSND's decision; and
- Send request to BCBSND at the address shown on Explanation of Benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription Drug benefits, Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); and
- Include a statement about why you believe that BCBSND's initial decision was incorrect, based on specific benefit provisions in this brochure and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and EOB forms.

This does not apply to provide and recommend removal.

- In the case of a post-service claim, BCBSND has 30 days from the date BCBSND's receive a request to:
    - Pay the claim or
    - Write to you and maintain the denial or
    - Ask you or your provider for more information.

You or your provider must send the information so that BCBSND receives it within 60 days of request. BCBSND will then decide within 30 additional days.

If BCBSND does not receive the information within 60 days, BCBSND will decide within 30 days of the date the information was due. BCBSND will base its decision on the available information at the time. BCBSND will write to you with its decision.

- If you do not agree with the decision, you may ask the U.S. Office of Personnel Management (OPM) to review it. You must write to OPM within:
    - 90 days after the date of BCBSND's letter upholding the initial decision; or
    - 120 days after you first wrote to BCBSND – if BCBSND did not answer that request in some way within 30 days; or
    - 120 days after BCBSND asked for additional information – if BCBSND did not send you a decision within 30 days after BCBSND received the additional information.

Write to OPM at:

United States Office of Personnel Management
Healthcare and Insurance, Federal Employee Insurance Operations
Health Insurance 1
1900 E Street NW
Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe BCBSND's decision was incorrect, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and Explanation of Benefits (EOB) forms;
- Copies of all letters you sent to BCBSND about the claim;
- Copies of all letters BCBSND sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, please clearly identify which documents apply to which claim.

Independent External Review Process

Independent External Review – Provider

Under certain circumstances, a provider may request an independent external review to determine if medical care provided was medically necessary and appropriate to the claim submitted by the healthcare provider and reviewed by BCBSND. An independent external review may be requested only after exhausting BCBSND's provider appeal process. BCBSND has contracted with an Independent Review Agency to conduct independent external reviewS.. BCBSND will provide the medical information and medical policies used in the provider inquiry and appeals process.

To complete the review, the form can be found at www.BCBSND.com/providers, Provider Services, Forms.

The Independent External Review process does not apply to the following and requests will be returned to the provider:

- Benefit Plan exclusions
- Self-funded employee benefit plans
- FEP

Independent External Review – Member

Under certain circumstances following completion of BCBSND's internal claim for benefits and appeals process, a member and/or a member's authorized representative may request an Independent External Review. The provider may request an Independent External Review on behalf of the member with a signed authorized representative form.

A request for Independent External Review is available only for determinations by BCBSND that are adverse to the member and based on medical necessity and appropriateness (including a determination that a treatment or service is investigative and/or experimental), health care setting, level of care, coding disputes based on medical necessity or effectiveness of a covered service, or a rescission. This request for Independent External Review must be submitted to the NDID or BCBSND by the first business day of the fifth month following BCBSND's final determination pursuant to the internal claims for benefits and appeals process.

A member and/or a member's authorized representative must adhere to the BCBSND internal claims for benefits and appeals process before requesting an Independent External Review under this provision unless:

- BCBSND waives this requirement
- BCBSND fails to comply with its internal claims for benefits and appeals process and this noncompliance cause, or is likely to cause, prejudice or harm to the member
- The member and/or a member's authorized representative requests an expedited internal claim for benefits and appeals review and an external claim for benefits and appeals review at the same time.

In pursuing any Independent External Review under this provision, no additional costs will be incurred by the member, the member and/or the member's authorized representative shall have the opportunity to submit additional information, and as appropriate under the terms of this benefit plan, the member's coverage will remain in effect pending the outcome of the Independent External Review process.

PREVENTIVE HEALTH BENEFITS AND CODING

The Preventive Health Benefits and Coding Guidelines provide additional information related to specific types of preventive services, as defined under the Affordable Care Act (ACA), which may be covered under a Member's Benefit Plan depending on factors such as grandfathered status, product type and anniversary date, and contraception exemptions.

The terms and conditions of the written Benefit Plan govern the benefits available to members and the guidelines do not guarantee coverage or payment for a particular service. Members

should contact Member Services at the telephone number and address on the back of their identification card for further preventive services information.

For specific information regarding current guidelines, please visit our website.

Affordable Care Act (ACA) Essential Health Benefits

The Affordable Care Act (ACA) requires that all health plans sold both on and off the Health Insurance Marketplace, offer a minimum level of coverage of Essential Health Benefits (EHB) in 10 categories:

- Outpatient care
- Inpatient care
- Emergency care
- Mental health services
- Prescription drug coverage
- Rehabilitative and habilitative services
- Preventive and wellness services
- Laboratory services
- Pediatric care
- Maternity and newborn care

Due to this ACA mandated requirement, BCBSND has created metallic health plans that are available both on and off the Health Insurance Marketplace. These metallic products are the ONLY products offered in the individual and small group markets. As a result, individuals enrolled in BCBSND existing non-grandfathered plans (individual or group policies issued after March 23, 2010) in the individual and small group markets were transitioned into the new metallic products in 2014. By the end of 2014, all of BCBSND's non-grandfathered business in the individual and small group markets was enrolled into a metallic product to ensure compliance with the Affordable Care Act.

A Sanford Health Plan health insurance product was selected by the NDID as the benchmark plan for the state of North Dakota, to provide a baseline of minimum coverage that other plans sold on the Health Insurance Marketplace must meet. Historically, BCBSND health plans offered richer benefits than those included in the Sanford benchmark plan. To conform to the provisions of the ACA including EHB, BCBSND recalibrated its medical, surgical, mental health and addictions benefits. These benefit changes are applicable to all metallic products, both on and off the Health Insurance Marketplace, in the individual and small group markets. FEP plans, non-grandfathered plans in the large group markets, and grandfathered plans (policies issued prior to March 23, 2010) were not impacted. Please contact Provider Services at 800-368-2312 or 701-282-1090 for information about which specific plans are impacted.

Metallic Products

The majority of BCBSND participating providers are in-network for all BCBCSND metallic health plans sold through the Federal Health Insurance Marketplace and metallic health plans sold off the Marketplace. BCBSND is utilizing our Preferred Blue PPO network for all products. No

separate application or contract is necessary to ensure in-network care for patients with a BCBSND metallic health plan if you participate in Preferred Blue. BCBSND metallic plans are:

- Blue Care
- Blue Direct
- Blue Essential

Patients with a BCBSND metallic health plan will have a unique ID card and accompanying ID card prefix, so that it is easily identifiable.

It's important for all providers to always verify benefits for patients prior to services because covered benefits, co-pays and other factors vary depending on each plan.

Commercial Risk Adjustment

Under the Affordable Care Act, everyone has access to health insurance irrespective of their health status. To create a system in which payer and providers are compensated for the risk associated with the members they treat (known as risk adjusted payments), a complete and accurate capture of each patient's health status through claims and encounter data is critical. Risk adjustment is designed to improve coverage, preserve consumer choice and improve quality of care for patients.

Risk adjustment relies on providers to perform accurate medical record documentation and coding practices in order to capture the complete risk profile of each individual patient.

A risk profile or risk score is calculated using diagnosis codes from claims. Risk scores are calculated based on demographic factor, diagnostic factors such as Hierarchical Condition Categories (HCCs), and cost sharing reduction factor.

Accurate medical records and diagnosis code capture on claims or encounter data the first time helps reduce the administrative burden and expense of adjusting claims. For providers involved in risk-sharing arrangements, it also ensures more accurate payment and reflection based on the severity of illness burden.

Documentation must be sufficient to support and substantiate coding for claims or encounter data.

- Diagnoses cannot be inferred from provider orders, nursing notes, or lab or diagnostic test results; diagnoses need to be in the medical record.
- Chronic conditions need to be reported every calendar year.
- Medical records need to legible, signed, credentialed and dated by the provider.
- Patient's name and date of service need to appear on all pages of the record.
- Treatment and reason for level of care need to be clearly documented; chronic conditions that potentially affect the treatment choices considered should be documented.

Accurate risk capture improves high-risk patient identification and the ability to reach out/ engage patients in disease and care management programs and care prevention initiatives. It also helps to identify practice patterns and reduce variation when clinically appropriate.

Annually, insurers are required to conduct an Initial Validation Audit (IVA). This audit is completed by an independent auditor approved by CMS to validate the member's health status through review of all relevant medical record documentation. CMS selects the member sample that will be audited. The auditor will review all claims and encounter data and medical record documentation from providers of service for coding accuracy. These results are provided to CMS. CMS will conduct a Second Validation Audit (SVA).

MEMBER ENGAGEMENT TOOLS

BCBSND members have told us that the affordability of their health insurance premiums — and the health care costs those premiums cover — is a major concern. Collaborative efforts are necessary to find ways to sustain and continuously improve quality of health care, while impacting an unsustainable and unaffordable rate of medical inflation.

Changing the way consumers view and understand the cost of health care will help them make more informed health care choices. To deeply engage these patients in their health and condition management, BCBSND is joining all Blue Plans across the country in participating in a suite of programs sponsored by the BCBSA, collectively known as the Consumer Transparency Initiatives.

Members can access this information on the Provider Finder. These transparency programs are:

Patient Review of Physicians (PRP)

Patient Review of Physicians (PRP) allows BCBSND members to view and post reviews of doctors and other professional providers based on their patient experiences. Members initiate physician reviews through our member portal. Once complete, reviews will be published on the Blue National Doctor and Hospital Finder website.

While patient reviews are just one of many factors to consider when choosing a health care provider, research shows that online patient review capabilities are in high demand. User-generated patient reviews are one of the most sought-after pieces of information for consumers looking for a new doctor, and approximately 85 percent to 90 percent of patient reviews are positive.

To assure that your overall score accurately reflects the quality of your patient experiences, encourage your patients to contribute to your reviews:

- To ensure accountability and validity, BCBSND has implemented a rigorous process that authenticates, verifies and moderate's reviews prior to posting online.
- Members respond to a core set of questions covering their overall experience, and reviews are checked for appropriateness prior to display.
- This process helps ensure that only authenticated BCBSND members who verify they have seen the doctor can contribute reviews.

Care Cost Estimator (CCE)/ Member Out-of-Pocket (MOP)

CCE is a web-based tool that estimates expected costs for services at various providers based on the member's health plan, network, and geographical area. Members will be able to get procedure cost estimates for a wide range of inpatient and outpatient surgeries and tests, X-rays and scans, lab tests, office visits and more:

- Online tool provides cost estimates for most inpatient/outpatient surgeries, procedures, tests and treatments
- Search for a procedure
- Keyword search bar to find your procedure
- Left Navigation options to refine your search
- Members may be directed to contact BCBSND Member Services at 844-363-8457 with questions.

BCBSND HEALTH PLANS

Preface: Under the Affordable Care Act (ACA), an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts) and meets other requirements.

Employer Group Plans are Referred to as "Group" Plans

Large Group Plans

Groups with 50 or more eligible employees are considered a large group. Under ACA, large groups are not required to have a Qualified Health Plan (QHP) at this time; however, they are required to implement ACA regulations. BCBSND provides several plan options to large groups.

BlueSaver is a High Deductible Health Plan (HDHP). The member is responsible for the cost-sharing amounts for services until the deductible is met. After the deductible is met, the member will pay a percentage toward services for the remainder of the calendar year, depending on plan design. When services are received with a BCBSND participating provider, benefits will be paid at the highest level. When services are received with a provider not participating with BCBS, benefits will be paid at a reduced level or no coverage. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member.

SelectChoice is a "Network" plan which requires members to choose a network affiliation. When services are received within the network, referred to as in-network, benefits will be paid at the highest level. When services are received outside of the network, benefits will be paid at a reduced level or no coverage. Members are responsible for copayments for certain services. For other services, after the deductible is met, the member will generally pay a percentage. The percentage may change depending on if the service is in or out-of-network. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member when received in-network. There is no coverage for these preventive services

when received out-of-network. There is also a SelectChoice Out-of-Area plan for members residing outside of a network area.

BlueChoice is a “Network” plan, which requires members to choose a network affiliation. When services are received in-network, benefits will be paid at the highest level. When services are received outside of the network, benefits will be paid at a reduced level or no coverage. BlueChoice does not have an annual deductible. Members are responsible for copayments for outpatient and inpatient services. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member when received in-network. There is no coverage for these preventive services when received out-of-network. There is also a BlueChoice Out-of-Area plan for members residing outside of a network area.

ClassicBlue is a “Traditional” plan and no network affiliation is required. Certain services are paid without having to meet the deductible, such as office visits. Members are responsible for copayments for certain services. For other services, after the deductible is met, the member will generally pay a percentage toward services. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member when received from a participating provider. When services are received from a BCBSND participating provider, benefits will be paid at the highest level. When services are received from a provider not participating with BCBS, benefits will be paid at a reduced level or no coverage.

CompChoice is a “Traditional” plan with no network affiliation required. Members are responsible for copayments for certain services. For other services, after the deductible is met, the member will generally pay a percentage toward services. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member when received with a participating provider. When services are received with a BCBSND participating provider, benefits will be paid at the highest level. When services are received with a provider not participating with BCBS, benefits will be paid at a reduced level or no coverage.

BasicBlue is a “Traditional” plan with no network affiliation required. After the deductible is met, the member will pay a percentage toward services for the remainder of the calendar year, depending on plan design.

There are no copayments for medical services. When services are received from a BCBSND participating provider, benefits will be paid at the highest level. Services received from a provider not participating with BCBS benefits will be paid at a reduced level or no coverage.

In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member when received from a participating provider.

PreferredBlue is a Preferred Provider Organization (PPO) plan. It is supported by the nationwide BlueCard PPO network. When services are received within the PPO network, benefits will be paid at the highest level. When services are received outside of the PPO network, benefits will be paid at a reduced level or no coverage. Members are responsible for copayments for certain services. For other services, after the deductible is met, the member will generally pay a percentage toward services received in the PPO network, depending on plan design. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member when received in-network.

Small Group Plans

With the implementation of ACA, for a group size of 2-49 eligible employees, two QHP group plans are offered.

BlueDirect is a Consumer Directed Health Plan (CDHP). BCBSND offers three plan options. It is supported by the Preferred Blue PPO network. When services are received within the PPO network, benefits will be paid at the highest level. When services are received outside of the PPO network, benefits will be paid at a reduced level or no coverage. The member is responsible for the cost-sharing amounts for services until the deductible is met. After the deductible is met, the member may pay a percentage toward services for the remainder of the calendar year, depending on plan design. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member.

BlueCare is a classic, comprehensive health plan with copayments. BCBSND offers six plan options. After the applicable deductible is met, the member will generally pay a percentage toward services. It is supported by the Preferred Blue PPO network. When services are received within the PPO network, benefits will be paid at the highest level. When services are received outside of the PPO network, benefits will be paid at a reduced level or no coverage. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the member.

Individual Plans (Non-employer Sponsored Coverage)

The term ‘individual’ is also applicable to an individual and their family members who are enrolled in their plan.

BlueDirect is a Consumer Directed Health Plan (CDHP). It is supported by the Preferred Blue PPO network. When services are received within the PPO network, benefits will be paid at the highest level. When services are received outside of the PPO network, benefits will be paid at reduced level or no coverage. The individual is responsible for the cost-sharing amounts for services until the deductible is met. After the deductible is met, the individual will pay a percentage toward services for the remainder of the calendar year, depending on plan design. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the individual.

BlueCare is a classic, comprehensive health plan with copayments. Individuals have copayments for office visits, emergency visits and prescription drugs. For other services, after the deductible is met, the individual will pay a percentage toward services. It is supported by the Preferred Blue PPO network. When services are received within the PPO network, benefits will be paid at the highest level. When services are received outside of the PPO network, benefits will be paid at a reduced level or no coverage. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the individual.

BlueEssential is a High Deductible Health Plan available to individuals younger than age 30, or those with financial hardships. After the deductible is met, the individual will not pay anything toward services for the remainder of the calendar year. It is supported by the Preferred Blue PPO network. When services are received within the PPO network, benefits will be paid at the

highest level. When services are received outside of the PPO network, benefits will be paid at a reduced level or no coverage. In accordance with ACA guidelines, certain preventive services are covered with no cost-sharing for the individual.

State and Federal Plans

CHAND, Comprehensive Health Association of North Dakota, offers health insurance to North Dakota residents who either are unable to find adequate health insurance coverage in the private market due to medical conditions or who have lost their employer-sponsored group health insurance. Insurance carriers licensed to do business in North Dakota must inform individuals denied health insurance coverage by their company about CHAND. CHAND covers major medical and prescription drug expenses, subject to benefit plan limitations and exclusions. Applicants are required to meet CHAND eligibility requirements to qualify.

Prenatal services

Federal Employee Program (FEP) The BCBSA is the trade association for the independent, locally operated Blue Cross and Blue Shield member companies. BCBSND is one of the 36 local member companies of the BCBSA. BCBSND is the primary point of contact for FEP members and is responsible for processing claims and providing customer service. The BCBSA negotiates annually with the U.S. Office of Personnel Management to determine the benefits and premiums.

FEP members choose between the Standard or Basic options. A few key differences are:

- The Basic option requires members to use preferred providers to receive benefits; members can go outside of the network with the Standard option.
- Standard option has a calendar year deductible, while the Basic option does not.
- Members will pay a copayment for most of the care they receive under the Basic option. Under the Standard option, their out-of-pocket costs include copayment and coinsurance amounts.

Grandfathered Plans – Group (large and small) and Individual Plans
Many provisions of ACA have been implemented since its inception in March 2010 and continue to affect health plans. Employers with grandfathered plans are allowed to continue with them if they abide by specific criteria; for instance, to not significantly modify their benefits. BCBSND adheres to the specific criteria set forth through ACA. Although grandfathered plans are not new purchase options; there are many plans in existence.

Grandfathered health plans are not required to include all health reform mandates; therefore, not all of the provisions will affect all members. Congruent with the large and small group grandfathered segments, Individual grandfathered health plans are not required to implement all of the health reform mandates.

A few of these mandates are:

- Preventive Services – the plan may have a maximum benefit allowance up to a certain dollar amount to use for screening services and the member will be responsible for the cost share of additional services above that set dollar amount. Grandfathered plans are not

required to implement U.S. Preventive Services Task Force A or B recommendations. Not all services will be covered with no cost share to the member.

- Women's Preventive Services – prevention-related services for women, such as contraception or support for breastfeeding equipment will not be covered at 100% with no cost share. The grandfathered plan designs vary as some may cover certain preventive services and some may not.

DEFINITIONS

Terms and definitions may not apply to all benefit plans. Please contact Provider Services for plan-specific information.

Affiliation

A clinic or group of independent physicians chosen by the members on the benefit plan from which they will receive health care services. This may also be referred to as the member's network.

Affordable Care Act (ACA)

ACA is legislation (Public Law 111-148) signed by President Obama on March 23, 2010. It is commonly referred to as the health care reform law, or Obamacare.

Allowed Charge

The maximum amount payable to a provider for a procedure or service. When seeking services from a BCBSND participating provider, the allowed charge (and any cost-sharing amounts) is accepted as payment in full for covered services.

Ancillary Services

All hospital services for a patient other than room and board and professional services. Laboratory tests and X-rays are examples of ancillary services.

Authorized Referral

Members may choose to receive services outside the Network without an Authorized Referral; however, these Covered Services shall be reimbursed at the out-of-network level. If a level or type of service is not available within the selected Network, an Authorized Referral is required to be eligible for benefits at the in-network level.

Benefit Period

A benefit period is one calendar year. It begins on January 1 of each year and ends on December 31 of the same year.

BlueCard Program

The BlueCard program allows BCBSND members the freedom to choose a Blue Cross Blue Shield provider anywhere in the United States — an important advantage if members receive

services outside North Dakota. More than 85 percent of all hospitals and health care providers nationwide participate with a Blue Cross Blue Shield plan.

Brand Name Drug

A brand name drug is a prescription drug with the registered trademark name given to the drug by its manufacturer, labeler or distributor.

Chiropractic Maintenance Care

Elective health care that is typically long-term, by definition not therapeutically necessary, but provided at preferably regular intervals to prevent disease, prolong life, promote health and enhance the quality of life. This care may be provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration, or it may be initiated with patients without symptoms in order to promote health and prevent future problems.

Claim

Information provided by a provider or a member to establish that services were provided. Participating providers submit the claim to BCBSND on the member's behalf.

Claim Number

A claim number is the number assigned to a claim for services when it is entered into the claims processing system.

Claim Status

"Processed claims" are claims that have been successfully processed through BCBSND's system. "In Process claims" are claims that haven't completed the processing cycle. This status does not apply to prescription claims.

Coinsurance Amount

A percentage of the allowed charge for covered services that is a member's responsibility. Some medical groups may require that the coinsurance amount be paid at the time of service.

Coinsurance Maximum

The limit set on the total coinsurance amount the member must pay during the calendar year.

Copayment Amount

A specified dollar amount payable by the member for certain covered services. Some medical groups may require that the copayment amount be paid at the time of service. Generally, copayment amounts do not apply toward the deductible or coinsurance maximum amounts.

Cost Sharing

The dollar amount a member is responsible for paying when covered services are received from a provider. Cost sharing amounts include deductible, coinsurance and copayment amounts.

Covered Services

Medically appropriate and necessary services and supplies for which benefits are available when provided by a provider.

Deductible

A specified dollar amount payable by the member for certain covered services received during the benefit period. Members must pay the amount of their deductible before BCBSND begins to share costs with them. Some medical groups may require that the deductible amount be paid at the time of service.

Dialysis Services

End Stage Renal Disease (ESRD) can be treated by either hemodialysis or peritoneal dialysis. Both dialysis treatments remove waste and extra fluid from the body. Hemodialysis is treated with the help of an apparatus called a dialyzer while peritoneal dialysis uses a combination of the lining of the peritoneal membrane and a solution.

Endoscopy/Multiple Endoscopies

Endoscopy is the examination and inspection of the interior of body organs, joints or cavities through an endoscope. An endoscope is a device that uses fiber optics and powerful lens systems to provide lighting and visualization of the interior of a joint. The portion of the endoscope inserted into the body may be rigid or flexible, depending upon the medical procedure.

Explanation of Benefits (EOB)

An Explanation of Benefits (EOB) is a document sent to the member by BCBSND after a claim for services has been processed. It includes the member's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by the benefit plan, non-covered services, cost-sharing amounts and the amount that is the plan holder's responsibility. This form should be carefully reviewed and kept with other important records.

Formulary Drug

A formulary drug is a brand name or generic prescription medication or drug that is safe, therapeutically effective, high quality and cost effective, as determined by a committee of physicians and pharmacists.

Generic Drug

A generic drug conveys the established or official chemical name of a drug, product or medicine.

Grandfathered Plan

A health plan that an individual was enrolled in prior to March 23, 2010 and is still enrolled in the plan. Grandfathered plans are exempt from most changes required by the Affordable Care Act

(ACA). New employees may be added to group plans that are grandfathered and new family members may be added to all grandfathered plans.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), otherwise known as HIPAA, was enacted as a broad congressional attempt at incremental health care reform. The “Administrative Simplification” section of that law requires the United States Department of Health and Human Services (DHHS) to develop standards and requirements for maintaining and transmitting health information.

Hospice Services

Hospice is defined as an organization that provides medical, social and psychological services in the home or inpatient facility as palliative treatment for patients with a terminal illness and life expectancy of less than six months. Precertification is required for all hospice services.

Identification Card (ID card)

A card issued by BCBSND to the plan holder as evidence of membership. The card includes the plan holder’s name, benefit plan number and type of coverage.

In-Network

Services a member receives from a provider within the member’s chosen network or affiliation. Members must obtain all medical services from this network for an entire year, beginning on the group’s anniversary date.

Inpatient – Skilled Nursing Facility

Skilled Nursing Facility (SNF) – A non-acute inpatient treatment center staffed with trained medical professionals. Typically, a SNF is a temporary residence for patients undergoing rehabilitation treatment.

Medically Appropriate and Necessary

A term used to describe those services, supplies or treatments provided by a provider to treat an illness or injury that satisfy the following criteria as determined by BCBSND:

- The services, supplies or treatments are medically required and appropriate for the diagnosis and treatment of a member’s illness or injury.
- The services, supplies or treatment are consistent with professionally recognized standards of health care.
- The services supplies or treatments do not involve costs that are excessive in comparison with alternative services that would be effective for diagnosis and treatment of the member’s illness or injury.

Member

The plan holder and, if single plus dependent, two party or family coverage is in force, the plan holder's eligible dependents.

National Provider Identifier (NPI)

A 10-digit number unique to each provider that is issued by the Centers of Medicare and Medicaid Services (CMS). The NPI is required for providers to submit transactions to federal and state agencies, as well as file claims with private health plans.

Network

A clinic or group of independent physicians. They have agreed to accept BCBSND- negotiated rates as payment in full, less cost-sharing amounts. See also In-Network and Out-of-Network.

Non-Formulary Drug

A non-formulary drug is any drug not on the formulary drug list. Also see Formulary Drug.

Online Explanation of Benefits (EOB)

An online Explanation of Benefits (EOB) is a document that members can view or print from claim detail on the website after a claim for services has been processed. It includes the member's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by the benefit plan, non-covered services, cost-sharing amounts and the amount that is the plan holder's responsibility.

Out-of-Network

Services members receive from a provider outside the member's chosen network. Higher cost share amounts will apply to out-of-network services (meaning the member will pay more out of pocket). A member can avoid out-of-network costs by obtaining an approved referral.

Out-of-Pocket Maximum

The total deductible and coinsurance amounts for certain covered services that are the member's responsibility during a benefit period. When the out-of-pocket maximum amount is met, the benefit plan will pay 100 percent of the allowed charge for covered services, less copayment amounts incurred during the remainder of the benefit period (until the end of the current calendar year). Copayment amounts do not apply toward the out-of-pocket maximum amount.

Participating Provider

A provider who has entered into an agreement with BCBSND to accept established negotiated rates as payment in full for covered services. Participating providers will submit claims for such members directly to BCBSND.

Precertification

The process of the member or the member's representative notifying BCBSND to request approval for specified services. Eligibility for benefits for services requiring precertification is contingent upon compliance with the provisions of a member's benefit plan.

Precertification does not guarantee payment of benefits.

Pre-existing Condition

A condition, disease, illness or injury for which the member receives medical advice or treatment six months or more prior to the effective date (for individuals/families) or enrollment date (for groups) of the member's benefit plan.

Prior Approval

The process of the member or member's representative providing information to BCBSND providing evidence of the medical appropriateness of specified services to BCBSND in order to receive benefits for such service. This information must be submitted in writing from the member's provider. BCBSND reserves the right to deny benefits if prior approval is not obtained before services are rendered.

Provider

A hospital, clinic, physician or other facility that provides health care services.

Service Date

The service date is the date on which services were provided to the member.