PPO (Prudent Buyer) and Select PPO Claims Submission

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Introduction

This section provides general billing guidelines and claim submission requirements for Anthem Blue Cross (Anthem). To assist the biller in reducing the number of returned claims, the manual identifies the more common situations that result in returned or rejected claims and processing delays. Also covered is an overview of electronic billing, and contact information for electronic data interchange (EDI) products and services.

SB 168: Use of Social Security Numbers

Background

California *Senate Bill 168* regulates the usage and disclosure of individual Social Security Numbers (SSNs). It is intended to provide additional protection against identity theft by limiting the use of an individual's SSN.

This law is not limited to the health care industry, but applies to all persons or entities that use SSNs to identify an individual. All federal, state and local agencies are exempt.

The intent of the law is to protect California residents. Consequently, all persons or entities that communicate with California residents by U.S. mail or via the Internet, and use or disclose these individuals' SSNs, may need to comply with the law by the relevant effective dates for their California contacts.

The law does not apply to individuals who travel to California, but reside in another state. In addition, the law does not prevent the collection, use or retention of SSNs as required by state or federal law, or the use of SSNs for internal verification or administrative purposes, as long as the use does not result in the public display or disclosure of the SSN as outlined in *SB 168's* restrictions.

Restrictions

SB 168 prohibits persons or entities from engaging in the following activities:

1. Publicly posting or displaying, in any manner, an individual's SSN
2. Printing an individual's SSN on any card required for the individual to access products or services provided by the person or entity (the identification card requirement)
3. Requiring an individual to transmit his or her SSN over the Internet, unless the connection is secure or the SSN is encrypted
4. Requiring an individual to use his or her SSN to access a website, unless a password, unique personal identification number, or other authentication device is also required

5. Printing an individual's SSN on any materials that are mailed to the individual, unless state or federal law requires the inclusion of the SSN on the document to be mailed; however, applications and forms sent by mail may include SSNs.

Anthem's Compliance Approach – Assign a Unique Member Identification Number

January 1, 2004 – New Individual and Group Policies

For new Individual and Group policies that are issued on or after January 1, 2004, Anthem will systematically assign new identification numbers and retain SSNs as a separate searchable identification number, allowing the provider to use either number.

The new unique identification number will replace the existing SSNs used today as the member's identification number. In most cases, new unique identification numbers will be an alphanumeric combination (e.g., XDM123A45678).

January 1, 2004 – Existing Group Policies

For employer groups that were in existence prior to January 1, 2004, Anthem systematically assigned new unique identification numbers and retained the SSN as a separate searchable identification number, allowing the provider to use either identification number.

The new unique identification number replaced SSNs that were used as the member's identification number on or before the group's renewal date, between July 1, 2004 and July 1, 2005.

Health Care Provider Compliance

Since health care providers are unable to determine whether policies are existing or new, and have no knowledge of group renewal dates, they were encouraged to discontinue all SSN disclosures as of January 1, 2003, to ensure compliance.

Additional Information

The above is being provided for informational purposes and should not be considered legal advice, or relied on as such. All health care entities should review the statute in order to gain a full understanding of, and to ensure compliance with, the law.

Additional information and guidance will be provided, as appropriate. A copy of *SB 168,* which restricts the use of SSNs, can be accessed at:
www.leginfo.ca.gov/pub/01-02/bill/sen/sb_0151-0200/sb_168_bill_20011011_chaptered.html
The portion of *SB 168* that relates to health care entities is codified in *Cal. Civil Code § 1798.85*. The *Official California Legislative Information* home page, which provides access to legislative and statutory information, can be accessed at **www.leginfo.ca.gov**.

Claims Settlement Practices

As required by *Assembly Bill 1455*, the California Department of Managed Health Care (DMHC) has set forth regulations establishing certain claim settlement practices and the process for resolving provider disputes for managed care products. The following notice is intended to inform you of your rights, responsibilities and related procedures, as they relate to claim settlement practices for commercial HMO, POS and, where applicable, PPO products where Anthem is delegated to perform claims payment. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in *Sections 1300.71* and *1300.71.38* of *Title 28* of the *California Code of Regulations*.

Information for Contracting Providers

Claim Submission Instructions

1. **Sending Claims to Anthem.** Send all hard copy claims to:

   Anthem Blue Cross
   P.O. Box 60007
   Los Angeles, CA 90060-0007

2. **Calling Anthem Regarding Claims.** Logon to ProviderAccess and see the *Directory of Services* section of the provider operations manual, under "Claims and Correspondence Mailing Addresses," for a list of telephone numbers by "Type of Plan."

3. **Claim Submission Requirements.** A list of commonly required claim attachments, supporting information and documentation required by Anthem may be found in the various Anthem operations manuals.

4. **Claim Receipt Verification.** To verify receipt of your claim, log on to ProviderAccess® at **https://provider2.anthem.com/wps/portal/ebpmybcc** You may also contact us by plan type at the telephone numbers listed in the *Directory of Services* section, as noted above. Your *Explanation of Benefits* (EOB) or *Remittance Advice* (RA) will verify receipt of your claim, as well.

Claim Overpayments

1. **Notice of Overpayment of a Claim.** If Anthem determines that it has overpaid a claim, Anthem will notify the provider, in writing, through a separate notice identifying the claim, the name of the member, the date of service(s), and a clear explanation of the basis on which Anthem believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

2. **Contested Notice.** If the provider contests Anthem's notice of overpayment of a claim, the provider, within 30 working days of receipt of the notice of overpayment of a claim, must send

written notice to Anthem stating the basis on which the provider believes that the claim was not overpaid. Anthem will process the contested notice in accordance with Anthem's contracted provider dispute resolution process, as described in the *Rights and Responsibilities* section of the provider operations manual.

3. **No Contest.** If the provider does not contest Anthem's notice of overpayment of a claim, the provider must reimburse Anthem within 30 working days of the provider's receipt of the notice of claim overpayment.

4. **Offsets to Payments.** If the provider does not reimburse Anthem within 30 working days of the provider's receipt of the notice of overpayment of a claim, then, pursuant to the Agreement, the provider authorizes Anthem to offset an uncontested notice of overpayment of a claim from the provider's current claim submission. Anthem may only offset an uncontested notice of overpayment of a claim against a provider's current claim submission when: (i) the provider fails to reimburse Anthem within the time frame set forth in **No Contest,** above, and (ii) Anthem's contract with the provider specifically authorizes Anthem to offset an uncontested notice of overpayment of a claim from the provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the provider's current claim or claims, pursuant to this section, Anthem will give the provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

Select PPO **Information for Nonparticipating Select PPO Providers**

If a member decides to seek treatment from a doctor or a facility that is not part of the Anthem Select PPO network, you should be aware that: 1) we make payments to a fixed schedule; and 2) reimbursements are calculated as a percentage of amounts according to our set schedule (the maximum amount we will reimburse for non-network providers). Therefore, if you are not part of the Select PPO network, you may bill the member directly for any amount in excess of the reimbursement schedule.

General Guidelines

Anthem establishes and, from time to time, revises unit values based on observed charge patterns of Physician's Current Procedural Terminology (CPT) and Centers for Medicare and Medicare (CMS) Healthcare Common Procedure Coding System (HCPCS) Level II codes. The presence of a code in the current CPT, HCPCS or other procedural manuals does not necessarily indicate Anthem allows the services. **Anthem retains discretion in the determination of payment structures.**

Anthem uses these guidelines for administrative purposes, such as claims processing and developing guidelines for Medical Review and Medical Policy.

The following are general claim submission guidelines:

PPO (Prudent Buyer) and Select PPO Claims Submission

1. **System Edits.** Edits are in place for both electronic and paper claims. Therefore, claims not submitted in accordance with requirements cannot be readily processed, and most likely are returned.

2. **HCPCS and CPT Codes.** Current *HCPCS* and *CPT Manuals* must be used because many changes are made to these codes every year. Anthem uses only current HCPCS and CPT codes. These manuals may be purchased at any technical book store, or by writing to:

   Mail Orders
   American Medical Association
   Attention: Order Processing
   P.O. Box 930876
   Atlanta, GA 31193-0876

   Or, by calling:

   a. MedicalCodingBooks.com: **866-900-8300**
   b. The American Medical Association: **800-621-8335**

3. **Reimbursement for HCPCS Level II Codes**

   a. **Pharmacy (including infusion therapy drugs).** For Standard Prudent Buyer contracts, starting July 1, 2005, the statewide maximum allowable will be based on 125 percent of the Average Sale Price (ASP) for drugs; starting May 1, 2006, allowable will be based on 110 percent of the ASP for drugs; starting August 30, 2007, the allowable will be based on 106 percent of ASP for drugs as published by the CMS, effective the first day of the calendar quarter following the quarterly CMS effective date. In the event that no ASP for drugs has been published by CMS for a specific drug, the statewide maximum allowable will be established by Anthem, considering claims and/or external data, including average wholesale price (AWP). The statewide maximum allowable for immune globulins, vaccines and toxoids will be established by ANTHEM and considers claims and/or external data, including Average Wholesale Price (AWP), which will be updated quarterly. Self-injected drugs for home use and all oral prescription drugs dispensed in the physician office will be denied, and the member may not be billed by the physician or other health care clinician. These drugs must be provided by a licensed pharmacy.

   b. **Injectable medications.** Injectable medications that are administered in the physician's office and/or other medical facility can be reimbursed when using the appropriate code that best describes the dosage being administered. To ensure appropriate allowances, include the units of occurrence in box "24G" (Units-Days) on the *CMS 1500* form.

   c. **Durable Medical Equipment (DME), Supplies (including, but not limited to, infusion therapy supplies), Prosthetics and Orthotics.** The maximum allowable will be determined by Anthem, based on claims data and/or external data. The maximum allowable will be based on whether the equipment is new, used or rented, as identified by the HCPCS Level II code modifier. Anthem may designate certain items as "rental only," "purchase only," or "rent to purchase." For "rent to purchase" items, the maximum allowable is the Anthem-determined purchase price; the rental price will not exceed the

purchase price. Codes not identified by a modifier as "purchase" will be considered rentals. DME equipment used in the physician's office is separately reimbursable. **Note:** Prosthetic appliances and devices are **not** considered DME expenses and are not subject to the contract's DME maximums. However, the member's contract may have a specific dollar maximum for prosthetic devices.

d. **Other HCPCS Codes.** For other HCPCS codes, the maximum allowable will be determined by Anthem using claims data and/or external data.

4. **Split-Year Claims.** For services that begin before December 31, but extend beyond December 31, split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and copayment maximums. Therefore, submit claims by single year only.

5. **Modifiers.** A modifier indicates that the procedure performed by the physician has been altered by some specific circumstance, but has not changed in its definition or code. The presence of a modifier in the current CPT, HCPCS or other procedural manuals does not necessarily indicate Anthem allows the services. Anthem retains discretion in the determination of payment structures.

   Modifiers may be billed in accordance with the *CPT* and *HCPCS* manuals to indicate the following:

   a. A service or procedure requiring a professional or technical component (Not all services are considered to have professional or technical components; some procedures are considered as professional only or global only.)
   b. A service or procedure performed by more than one physician and/or in more than one location
   c. A service or procedure that increased or was reduced
   d. A service or procedure rendered more than once
   e. Partial procedure performed
   f. Adjunctive services
   g. Bilateral procedures
   h. Unusual events occurred
   i. Effective January 1, 2001, modifier 27 was no longer accepted for technical component; use "TC" to indicate the technical component. The American Medical Association (AMA) has designated Modifier 27 for "Multiple Outpatient Hospital E/M Encounters" on the same date.
   j. When billing Modifier 22, the physician must include an operative report or medical records.

6. **Cardiac Catheterization.** For cardiac catheterization codes, physicians are required to bill with

Modifier 26 to reflect the professional service.

7. **Anesthesia Codes and Modifiers.** To be consistent with industry guidelines, Anthem changed its anesthesia service billing procedures to conform to the practice of using only current CPT codes 00100 through 01999 when billing for anesthesia administration. Anthem does not accept the practice of billing anesthesia services using surgical codes with a modifier (e.g., 23, 30 or P1).

   In addition, when two or more anesthesia procedures are billed during the same operative session, only the anesthesia procedure with the higher base unit value is allowed for reimbursement.

8. **Anesthesia Time.** To more accurately calculate and reimburse health care professionals for anesthesia services, Anthem requires all anesthesia services to be billed using minutes.

9. **Unlisted Procedure or Service.** There may be services or procedures performed by physicians that are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, Anthem needs a description of the service to calculate the appropriate reimbursement, and medical records may be requested.

10. **CPT Code 99070.** CPT code 99070 (supplies and materials provided by the physician over and above those usually included with the office visit or other services) is not accepted by Anthem. Health care professionals are to use HCPCS Level II codes, which give a detailed description of the service provided. Anthem will follow Medicare guidelines and cover surgical trays only for specific surgical procedures. Surgical trays billed with all other services will be considered incidental and will not be payable separately.

11. **Multiple Surgeries.** Multiple surgery claims are priced based on major and minor procedures. The surgical procedure with the highest Anthem unit value is considered the major procedure and is priced at 100 percent of the unit value. The minor surgeries have a lesser unit value and are reduced as follows:

Procedure Position	Allowance
Second Procedure	50 percent of allowed amount
Third Procedure	25 percent of allowed amount
Fourth Procedure	25 percent of allowed amount
Fifth Procedure	25 percent of allowed amount

Claims submitted with more than five surgeries are referred to Medical Review for pricing determination.

Effective December 15, 2006:

Multiple Surgery Reduction – Surgical procedures that can be billed with multiple units of occurrence will be subject to the same Multiple Surgery Reduction (MSR) rules as those billed on separate lines. We will update our payment system so that, regardless of whether these procedures are billed on one line or multiple lines, the MSR reimbursement rules will apply.

Incidental Services – There are a number of services that are being billed separately, but should be considered "incidental" when they are provided with another procedure. We have updated our payment system to identify these incidental codes.

12. **Laboratory Claims.** Physicians must supply laboratories with a diagnosis, correct patient information (including full name and date of birth), and appropriate billing information. This information is important to ensure that laboratories have the appropriate information to bill Anthem.

Common Reasons for Rejected and Returned Claims

Many of the claims returned for further information result from common billing errors. The following is a list of some of the more common situations:

1. **Alpha prefix on subscriber identification not provided for BlueCard.** The three-digit alpha prefix is critical for properly identifying and routing all paper claims (e.g., Blue Cross and Blue Shield plans, such as the BlueCard PPO).

2. **Date of injury not provided.** When charges represent an injury diagnosis, provide a date of injury.

3. **Other carrier *Explanation of Benefits* (EOB) not provided.** When billing Anthem as a secondary payor, a copy of the primary carrier's EOB must be attached.

4. **Duplicate billings.** Overlapping dates of service for the same service(s) create a questionable duplicate bill.

5. **DSM-IV diagnosis coding denied.** ICD-9 codes should be used when billing diagnosis codes.

6. **ICD-9-CM codes denied.** Claims that are coded with a preliminary, rather than a definitive diagnosis are mailed back for the definitive diagnosis.

7. **Member identification number is incomplete.** Specifically in the case of Federal Employee Program (FEP) (except for Anthem Blue Cross HMO FEP) claims, the alpha prefix is omitted in addition to other numeric digits. The FEP identification number starts with an alpha "R" and is followed by eight numeric digits. Supply the nine-digit identification number for all FEP submissions.

8. **Request for medical records.** When returning records to Anthem, it is imperative that the

records are attached to the original mail-back form. Do not re-attach a new copy of the claim. Do not combine other mail-backs in the same envelope, since it is likely that the records will not arrive in the correct department.

9. **Unlisted HCPCS codes submitted without description.** A full description of unlisted HCPCS codes should be included on claims. When submitting claims electronically, enter the description in the "Remarks" field.

10. **Unreasonable numbers submitted.** Do not use unreasonable numbers (e.g., 999) in the "Units" field; units greater than 999 should be indicated on the claim or in the "Remarks" section, if billing electronically.

Claim Follow-Up

The *Claim Follow-Up form* is for routine claim follow-up and/or for the submission of additional information needed to process a claim. The form highlights the key claims information necessary for Anthem's reconsideration. It should be used for all claims needing follow-up. To request such a reconsideration, attach the *Claim Follow-Up form* to the top of a copy of any applicable correspondence that was received from Anthem, along with any other relevant documentation needed to process the claim. With the exception of **corrected billing** and **nonmember donor claims**, a copy of the claim should **not** be resubmitted with the requested documentation.

Providers often resubmit copies of claims that have been rejected, denied or deemed incomplete, along with the additional information requested by Anthem. Under review, these copies are regularly treated as duplicate submissions.

Use of this form will help providers avoid this pitfall by providing the follow-up claims information only. The *Claim Follow-Up form* identifies the common claim submission errors in order to minimize the need for explanation. The form will lessen your administrative burden and help get the claim reprocessed as expeditiously as possible.

After completing the form, place it on top of all documentation and mail it to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Electronic Claims Submission

Introduction

In recent years, Anthem customers have made unprecedented demands that we reduce administrative costs. One major cost driver is the submission and processing of paper claims. With

the increased acceptance of computer technology, in general, and electronic billing technology, in particular, Anthem strongly promotes using this technology for claims submission. In addition to providing the capability to more easily measure the quality of claims processing and production, electronic claims submission leads to increased productivity, efficiency and service. For more information about electronic billing options, call **800-227-3983**.

What Is EDI?

Electronic data interchange (EDI) is the computer-to-computer exchange of common business transactions using a standard electronic format.

A clearinghouse is considered an electronic post office, but not EDI in general.

EDI has often been likened to using an ATM card to handle financial transactions. It is one computer talking to another computer to transmit transactions and information between business partners. EDI can also transfer claim payments to your bank account (Electronic Funds Transfer) and deliver your *Electronic Remittance Advice* (ERA) for your immediate retrieval, so you can reconcile your account quickly. Furthermore, EDI enables encounter data submission, eligibility and benefit inquiries, and claim status inquiries. EDI is an effective tool for reducing administration costs in the health care industry.

How It Works

A computer modem, cable line, or wireless connection enables you to send and receive vital information, such as claims, encounters, eligibility and claim-status transactions, and ERAs. Anthem partners with many software vendors, clearinghouses and billing services that collect the data you submit and send it to us electronically. Most of these partners are also linked to hundreds of health care EDI networks.

Benefits to You

One-Address Billing. With electronically submitted claims, all Anthem claims are sent to one destination, and Anthem automatically routes your claim to the proper processing site.

Savings. By reducing the cost of purchasing *CMS 1500* forms, mailing envelopes, postage stamps and printing costs, you can easily recognize the savings. Your billing staff will also spend less time on claim payment follow-up because priority processing is given to electronic claims.

Positive Acknowledgement Report. This report displays both accepted and rejected claims. You will receive a *Positive Acknowledgement Report* if you submit claims directly to Anthem. If you use a clearinghouse or vendor to transmit claims, you may wish to consult that entity for a copy of the *Positive Acknowledgement Report*. Some vendors and clearinghouses do not forward this report, but use its raw data to create their own report. Corrected claims should be resubmitted electronically in a timely manner.

PPO (Prudent Buyer) and Select PPO Claims Submission

Getting Started

If you have any questions or problems, call Anthem's EDI Services department at **800-227-3983**. You may also visit Anthem's website, at **www.anthem.com/ca/home-providers.html** for more information. There, on the "Provider" home page, look for the "Provider Services" link at the top of the page. Be sure to then select the "EDI Services" link**.** Click on the *Live Help* link for EDI live chat capability. Our EDI analysts are very knowledgeable, and can assist you with your questions regarding electronic billing and other available electronic services.

Hard Copy Billing

Participating health care professionals that are not set up to process claims electronically are required to submit all hard copy claims on the *CMS 1500* form (with scannable "red dropout ink"). All applicable data element blocks must be complete. If the form is incomplete, it is returned for the additional information needed for processing.

The consolidated address for Anthem claims and claims-related correspondence is:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Tips for Clean Paper Claims Submission

1. **Tracer claim (possible duplicate).** To avoid a claim being rejected as a duplicate, make sure the claim has not been previously received and denied, or rejected, for missing information by first checking the status of the claim using ProviderAccess. For more information on ProviderAccess, refer to .

2. **Invalid or missing license number.** A valid license number must be included on the claim.

3. **Tax identification number invalid.** All professional claims must include an accurate tax identification number.

4. **Provider Locator Code missing.** Include your locator code if multiple addresses or offices are on our database, so your payment can be sent to the correct location.

5. **Member not identified.** Verify that membership data, such as certificate number and group numbers, including prefixes, are correct. If the member is from out-of-state, include a copy of his or her identification card.

6. **Invalid date of birth.** Date of birth must be included and correct. Be careful not to transpose the dates.

7. **Code invalid.** Verify that ICD-9, CPT/HCPCS, and procedure codes are appropriate and valid.

8. **Modifier invalid.** Make sure the correct modifier is submitted when required.

9. **Diagnosis code not referenced.** All diagnosis codes on professional claims must be referenced to a procedure. For example, if you list three diagnosis codes, the second and third diagnosis codes must also be referenced to at least one procedure code.

10. **Possible duplicate line on same claim.** Detail-line items on the same claim should be checked to ensure that they are not duplicated.

11. **Detail line incomplete.** Verify that all fields are completed accurately.

12. **Include all attachments.** This means medical records, surgical reports, prior authorizations, etc., when required.

13. **Illegible claim form or data.** To ensure readable image quality, avoid submission of dot-matrix printed documents and lightly printed or carbon forms. Stamp or write messages in blue or black ink, rather than red, because image scanning filters out red ink on documents. Use the "Remarks" field on claim forms for messages. Do not stamp or write over boxes on the claim form. Avoid stamping messages regarding regulatory filing requirements or timely filing limits — doing so can interfere with the ability to produce a claim that is clean and processable. Use the "Remarks" field to stamp or write "Tracer" or "Past Due" on the claim.

Where and How to Submit BlueCard® Program Claims

You should always submit BlueCard claims to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

Include the member's complete identification number when submitting the claim. The complete identification number includes the three-character alpha prefix. Incorrect or missing alpha prefixes and member identification numbers delay claims processing.

Once Anthem receives the claim, it will electronically route the claim to the member's Blue Cross and Blue Shield Plan. The member's plan then processes the claim and approves payment; Anthem will pay you.

If you are a non-PPO (traditional) provider and are presented with an identification card with the "PPO in a suitcase" logo on it, you should accept the card and file with Anthem. You will be given the appropriate traditional pricing.

International Claims

The claim submission process for international Blue Cross and Blue Shield Plan members is the same as for domestic Blue Cross and Blue Shield Plan members. You should submit the claim directly to Anthem.

Indirect, Support or Remote Providers

If you are a health care provider that offers products, materials, informational reports and remote analyses or services, and are not present in the same physical location as a patient, you are considered an indirect, support or remote provider. Examples include, but are not limited to: prosthesis manufacturers, DME suppliers, independent or chain laboratories, and telemedicine providers. If you are an indirect provider for members from multiple Blue plans, follow these claim-filing rules:

- If you normally send claims to the direct provider of care, follow normal procedures.
- If you do not normally send claims to the direct provider of care, file the claim with Anthem.

Exceptions to BlueCard Claims Submissions

Occasionally, exceptions may arise in which Anthem will require you to file the claim directly with the member's Blue Plan. Here are some of those exceptions:

- You contract with the member's Blue Plan (for example, in contiguous county or overlapping service area situations).
- The identification card does not include an alpha prefix.

In some cases, Anthem will request that you file the claim directly with the member's Blue Plan. For instance, there may be a temporary processing issue at Anthem, the member's Blue Plan, or both that prevents completion of the claim through the BlueCard Program.

When in doubt, send the claim to Anthem at:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060-0007

We will handle the claim for you.

Claims for Accounts Exempt from the BlueCard Program

When a member belongs to an account that is exempt from the BlueCard Program, Anthem will electronically forward your claims to the member's Blue Plan. That means you will no longer need to send paper claims directly to the member's Blue Plan. Instead, you will submit these claims to

Anthem. Medicare Supplemental and Medicare Risk are required to put alpha prefixes on their members' identification cards. However, you will continue to submit Medicare Supplemental (Medigap) and other coordination of benefits (COB) claims under your current process.

How the Electronic Process Works

- You will submit claims with alpha prefixes directly to Anthem, which will forward the claims to the member's Plan for you.
  - It is important for you to correctly capture the member's complete identification number on the claim, including the three-character alpha prefix at the beginning. If you don't include this information, Anthem may return the claim to you, and this will delay claims resolution and your payment.
  - It is also important for you to call BlueCard Eligibility at **800-676-BLUE**, or **800-676-2583**, to verify the member's eligibility and coverage.
- If the member's claim is exempt from the BlueCard Program, Anthem will inform you that the claim is being forwarded to the member's Plan. In some cases, the member's Blue Plan may contact you for additional information. For example, if the member's Plan cannot identify the member, the member's Blue Plan may return the claim to you just as it would currently with a paper claim. If this happens, verify the billing information and resubmit the claim with the additional or corrected information to Anthem.
- The member's Blue Plan will send you a detailed *EOB/Payment Advice* with your payment or a notice of denial. If you have already been paid or you do not contract with Anthem, the member's Blue Plan may pay the member.

Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we make sure people receive full benefits, and how we prevent double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If after calling **800-676-BLUE**, or **800-676-2583**, or through other means you discover the member has a COB provision in his or her benefit plan, and another insurance carrier is the primary payor, submit the claim, along with information regarding COB, to Anthem. If you do not include the COB information with the claim, the member's Blue Plan or the other insurance carrier will investigate the claim. This investigation could delay your payment or result in a post-payment adjustment.

Payment for BlueCard Claims

If you haven't received payment, do not resubmit the claim. If you do, it will be denied as a duplicate. This will also confuse the member because he or she will receive another EOB and will need to call Customer Service. Timing for claims processing varies at each Blue Cross and Blue Shield Plan. You can check the claim payment in ProviderAccess®, at **https://provider2.anthem.com/wps/portal/ebpmybcc**.

In some cases, a member's Blue Cross and Blue Shield Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, Anthem may either ask you for the information or give the member's plan permission to contact you directly.

How to Handle Calls from Members and Others with Claims Questions

If a member contacts you, tell them to contact their Blue Cross and Blue Shield Plan. Refer them to the front or back of their identification card for a Customer Service number. The member's plan should not be contacting you directly, unless you filed a paper claim directly with that plan. If the member's plan contacts you to send another copy of the member's claim, refer the plan to Anthem.

Where to Find More Information About the BlueCard® Program

For more information about the BlueCard Program, call Anthem at **800-444-2726**, or visit the Blue Cross and Blue Shield Association's website at **www.bcbs.com**.

Health Care Professional License

Anthem requires health care professionals to include their state license number and the ZIP code for their practice (the location where services are rendered) when submitting claims. All professional claims submitted to Anthem must include this information, consistent with *Section 6.9* of the *Prudent Buyer Plan Participating Physician Agreement*. If the tax identification number is that of a medical group, the rendering physician's name and license number must also appear on the claim. All license numbers are validated against the license number file from the California Board of Consumer Affairs.

On the *CMS 1500* form, the license number is entered in box number "19" and the ZIP code in box number "32." The state license number and practice ZIP code requirements apply to optical character recognition (OCR) scannable paper claims, non-scannable *CMS 1500* paper claims, and electronically submitted claims.

Claims submitted without a state license number may be returned and have processing delays.

The following areas or health care professionals are not required to provide Anthem with a state license number (exempt health care professionals must still include practicing ZIP code):

- Air ambulance
- Blood bank
- Christian Science nurse
- Christian Science practitioner
- Donor bank
- Group ambulance
- Independent laboratory
- Medical vendor (DME)
- Magnetic resonance imaging (MRI)
- Occupational therapy
- Optician
- Orthotics/prosthetics
- Pharmacy
- Portable X-ray
- Anthem PPO (Prudent Buyer Plan) clinical laboratory
- Anthem PPO (Prudent Buyer Plan) diagnostic imaging/MRI

Claim Submission Filing Limits

Physicians must submit a claim to Anthem on forms, and in a manner acceptable to Anthem, within 12 months of performing the medical services described in the claim. Anthem may contractually deny a claim submitted beyond that 12-month claim-filing limit. The patient/member to whom the services were rendered is not liable for the amount of the claim. If the physician believes that the claim was, in fact, submitted timely despite Anthem's denial, the physician may submit evidence of such timely filing. Such evidence must be attached to the back of the Anthem mail back or denial EOB, and submitted in a timely manner for reconsideration of the initial denial. **Do not resubmit the original claim.**

Note: The 12-month claim filing limit also applies to adjustments when Anthem is the primary carrier. For claims involving COB with another carrier or Medicare, the date of the other carrier's EOB or Medicare's EOB is used for determining the eligible submission period.

In many cases, Anthem will accept such resubmitted claims. Anthem may, for example, accept the following as evidence of timely **electronic** submission:

- Computer-generated billing ledgers with the Anthem name from a billing system
  - If a locator code is used instead of the billing address, a list of locator codes/corresponding addresses must be provided.
  - A ledger must have several claims listed.
- Clearinghouse report (e.g., NEIC) of acceptance by Anthem
- *Dated request for Additional Information* form (from Anthem)
- Anthem-generated *Positive Acknowledgement Report* (Should you need your report re-created during the first 30 days after submission, call **800-227-3983**, option #1.)
- Claim denial letter or EOB from Anthem
- For EDI claims that could not be processed by Anthem:
  - Copy of Anthem's dated letter to provider requesting a resubmission; or
  - Anthem Batch Number for claims (or other identifying information) or error listing

Anthem may, for example, accept the following as evidence of timely **hard copy** submission:

- Computer-generated claim transaction history with the Anthem name from a billing system
  - If a locator code is used instead of the billing address, a list of locator codes/corresponding addresses must be provided.
  - You must include billing history and history of timely follow-up attempts made within contracted timely filing guidelines.
  - A ledger must have several claims listed.
- Dated *Request for Additional Information* form (from Anthem)
- Claim denial letter or EOB from Anthem

Anthem accepts the following as proof of submission when initially **sent to another carrier**:

- Denial letter, dated and printed on letterhead, from other insurance carrier; or
- Dated EOB from other insurance carrier

HIPAA regulations do not allow us to request documents that contain more than just the claim in question and, in addition, if the provider sends us a ledger with multiple claims listed, then the provider would be in violation of HIPAA.

Anthem reserves the right to use its sole discretion in determining whether the information supplied is acceptable for timely filing purposes.

Anthem may, for example, not accept the following as evidence of timely submission:

- Reports from the provider system indicating that the claim was submitted to the clearinghouse (In some cases, claims error out and do not enter the Anthem claims system; the originator receives notice of these in the form of an error report)

- Patient transaction history without consistent and timely follow-up attempts made within contracted timely filing guidelines

Billing References

This manual, when used with the following references, provides detailed instructions on billing:

1. *CPT-4* (current year). American Medical Association. To order, call **800-621-8335**.
2. *CMS Common Procedure Coding System* (HCPCS), National Level II (current year). Practice Management Information Corporation (PMIC). To order, call **800-633-7467 (MED-SHOP)**.
3. *ICD-9 CM,* Fifth Edition, Ninth Revision, Volumes 1, 2, 3 (2000). Practice Management Information Corporation (PMIC). To order, call **800-633-7467 (MED-SHOP)**.

Highlights of 2007 Code Changes

Anthem only accepts current CPT and HCPCS codes to identify services rendered. Reimbursement for these services is subject to the terms of your Agreement and the member's benefit plan. The following are highlights of the 2007 code changes, organized by service category. For a comprehensive list of the codes and revisions, refer to the most current CPT and HCPCS codes.

Anesthesia

Two new codes were added for 2007 to report services administered during transthoracic procedures on the spine and cord.

00625 – Anesthesia for procedures on the thoracic spine and cord via an anterior transthoracic approach

00626 - Utilizing one lung ventilation

Surgery

Destruction of Lesions

Codes 17000 through 17004 have been revised to distinguish the services described by these codes.

Destruction of lesions revised codes will be used only for the treatment of premalignant lesions by any one of the described methods:

- Laser electro surgery
- Cryosurgery
- Chemosurgery
- Surgical curettement

Codes 17110 through 17111 have been revised to limit reporting. These procedures will be used for the treatment of benign lesions.

Mohs Micrographic Surgery:

For 2007, procedure codes 17304 through 17310 have been deleted, and codes 17311 through 17315 were established in an effort to more accurately describe Mohs surgery procedures based on anatomic site.

- **17311 Head, neck, hand, feet, genitalia or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels**
- **17312 Second and subsequent stage code**
- **17313 Trunk, arms or legs**
- **17314 Second and subsequent stage code**
- **17315 Replaces 17310 for additional blocks beyond the first five blocks on a given stage.**
  - Billed once per additional tissue block

Breast

For 2007, a new subheading under the excision heading for Breast was titled "Mastectomy Procedures," all eight procedures have been renumbered and relocated:

- **19140 renumbered to procedure code 19300**
- **19160 renumbered to procedure code 19301**
- **19162 renumbered to procedure code 19302**
- **19180 renumbered to procedure code 19303**

- **19182 renumbered to procedure code 19304**
- **19220 renumbered to procedure code 19306**
- **19240 renumbered to procedure code 19307**

Spine

For 2007, several procedure codes were converted from Category III codes to a Category I code.

- **0062T > 22526 Percutaneous intradiscal electro thermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level**
- **0063T>22527 one or more additional levels**
  Total Disc Arthroplasty
  - **0091T>22857**
  - **0094T>22862**
  - **0097T>22865**

Cardiovascular System

For 2007, new Cardiac Surgery codes:

- New codes for placing an epicardial electrode
  - **33202 open incision**
  - **33203 endoscopic approach**
- Open Maze codes
  - **33254-33266**
- Septal Defect
  - **33675-33677**
- Venous Anomalies
  - **33724 through 33726**

Radiology

For 2007, new subhead titles were created to designate code sections for the follow major sections:

Radiological Guidance

- **Fluoroscopic guidance for procedure codes 77001 through 77003**
- **Computer tomography guidance for procedure codes 77011 through 77014**

- **Magnetic resonance guidance for procedure codes 77021 through 77022**
- **Other radiologic guidancefor procedure codes 77031-77032**

Breast, Mammography

All codes for breast imaging procedures relocated to new "Breast, Mammography" subsection:

- **76082 (CAD, Dx mammo)>77051**
- **76083 (CAD screening mammo)> 77052**
- **77086 (Single ductogram) > 77053**
- **77088 (Multi ductogram) > 77054**
- **76090 (DX mammo, unilat) > 77055**
- **76091 (DX mammo, bilat) > 77056**
- **76092 (Screen mammo, bilat) > 77057**
- **76093 (MRI breast, unilat) > 77058**
- **76094 (MRI breast, bilat) > 77059**

Bone Joint Studies

- **77071 through 77084**

Pathology and Laboratory

For 2007 guidelines for the direct reporting of antibody detection testing have been revised to reflect appropriate reporting for immune globulin assays.

- **86602 through 86804**

Medical Services

Vaccines, Toxoids

The age specific vaccine product codes (see below) have been revised to not be defined by a particular age population, but by the population to which the vaccine is administered. ("When administered to" replaced by "for use in individuals")

- **90655 through 90658, 90669, 90700, 90702 90714 through 90715, 90718, 90732**

Ventilator Management

Subheadings were added to the "Pulmonary Procedures" subsection to accommodate the addition of four new codes for ventilator management.

- **94022 through 94005**

New Appendix M

Appendix M – Crosswalk to Deleted CPT Code