CapsuleNews℠

A NEWSLETTER FOR MONTANA HEALTH CARE PROVIDERS
Fourth Quarter 2011

HIPAA 5010 Compliance Date is January 1, 2012

Blue Cross and Blue Shield of Montana (BCBSMT) is continuing to take action to comply with the Health Insurance Portability Act of 1996 (HIPAA) Version 5010 transaction standards. HIPAA requires the health care industry to implement mandated standards in the electronic transmission of health care transactions, including claims, remittance, eligibility, claims status requests, their related responses, and privacy and security standards. On January 15, 2009, the Secretary of the Department of Health and Human Services (HHS) adopted ASC X12 Version 5010 and NCPDP Version D.0 as the next standard for HIPAA-covered transactions. The Version 5010 upgrade will replace the Version 4010 transaction standards in order to improve and enhance administrative data exchanges.

All covered entities (providers, health plans, and clearinghouses) must convert from the current HIPAA Version 4010 electronic transaction standards to Version 5010 by January 1, 2012. BCBSMT will use *only* X12 Version 5010 for HIPAA transactions after that date.

5010 affects the following business processes:

- Claims (837 Institutional, Professional, Dental)
- Claim Status Inquiry/Response (276/277)
- Remittance (835)
- Enrollment (834)
- Premium Payment (820)
- Eligibility Inquiry/Response (270/271)
- Referrals and Prior Authorizations (278)

Systems that submit claims, receive remittances, and exchange claim status or eligibility inquiries and their responses must be analyzed to identify software and business process changes. You should be working with your vendors or clearinghouses to ensure compliance.

Should you have questions about this communication, please call your Health Care Services Provider Account Consultants at 1-800-447-7828, Extension 6100, Option 3; you may also email them at hcs_x6100@bcbsmt.com.

HMK Providers May Be Contacted For Medical Records

Healthy Montana Kids (HMK) (formerly CHIP) is a mandatory participant in the federal Office of Management and Budget (OMB) Payment Error Rate Measurement (PERM) program. The PERM program reviews and evaluates payment accuracy for health care services provided to HMK and Montana Medicaid members.

Beginning October 1, 2011, A+ Government Solutions will contact selected HMK providers to collect HMK members' medical records needed to support claims' payment accuracy. A+ Government Solutions is the national contractor selected by the Centers for Medicare and Medicaid Services (CMS) to perform these services.

HMK providers are selected by random sampling for review in coordination with claim payments. The contractor will contact each provider to verify name, address and identify the provider's preference in receiving the subsequent medical records' request(s) by fax or mail. Providers are to submit the requested information electronically or in hard copy within 75 days to A+ Government Solutions. The contractor will be in contact with the HMK providers to assure all needed documentation is received in a timely manner.

The Social Security Act requires the necessary documents be provided in order to complete the PERM review and

these medical records' requests are permissible under HIPAA.

It is critical HMK providers appropriately respond to any A+ Government Solutions' medical record request since the payment accuracy cannot be supported without the corresponding records. If providers fail to respond or provide all requested information, the State (HMK) will be cited with an error, resulting in an overpayment recovery from the provider.

Montana Medicaid is also a mandatory participant in the PERM review. The Montana Department of Public Health and Human Services (DPHHS) Program Compliance Bureau is available to assist providers in identifying the required documentation for submission. A summary of the minimum required documents to support claim payments is available at the following Montana Medicaid website in the *October 2011 Claim Jumper* edition, view here.

If you have any questions, contact DPHHS manager Steve Kranich at (406) 444-9356.

BlueCard Program Claims Filing

The BlueCard Program is a national program that enables members traveling or living in another Blue Cross Blue Shield (BCBS) Plan's area to receive the same benefits and BCBS provider access. The BlueCard Program allows health care providers to submit claims for members from other BCBS Plans, including international BCBS Plans, directly to their Local Blue Plan. In general, Montana providers are required to file their claims with BCBSMT.

Effective October 16, 2011, if a Blue Plan receives a claim directly from a provider or clearinghouse acting on behalf of a provider, for services rendered outside their Service Area (rendered in another Blue Plan's Service Area), the claim will be returned to the provider, or clearinghouse , or notification will be sent, with filing instructions that the claim must be refiled with the appropriate local Blue Plan. Blue Plans will no longer have the capability to route incorrectly filed claims among Blue Plan themselves.

Ancillary/Remote providers, defined as independent clinical laboratories (Labs), durable/home medical equipment (DME) suppliers and specialty pharmaceutical providers, must submit claims as follows:

Provider Type	**Submits to….**
Independent Clinical Laboratories (Labs)	The Plan in whose services area **the specimen was drawn.**
Durable/Home Medical Equipment (DME)	The Plan in whose services area **the equipment was shipped to or purchased at a retail store.**
Specialty Pharmacy	The Plan in whose services area **the ordering physician is located.** • Specialty Pharmacy is characterized as non-routine, biological therapeutics ordered by a health care professional as a covered medical benefit as defined by the Plan's Specialty Pharmacy formulary. • Specialty Pharmacy generally includes injectables and infusion therapies, high-cost therapies, and therapies that required complete care. Examples of major conditions these drugs treat include, but are not limited to, cancer, HIV/AIDS and hemophilia.

In the event a Plan incorrectly receives a claim from a remote provider, the Plan will return the claim to the provider or clearinghouse with instructions to file the claim to the appropriate Blue Plan as described above.

Please refer to the BCBSMT Provider Manual, Chapter 5, BlueCard Program (Out-of-State Claims), for further details on BlueCard Claims submissions, including product exclusions.

Cut the Cord and Go Online!

TriWest Healthcare Alliance's self-service tools for providers and their office staff can make daily office work more convenient, immediate, faster and easier.

Convenient
Using the tools offered on TriWest's secure provider website allows you to conveniently check your patients' eligibility, submit and check status of referrals and authorizations, as well as submit and check status of claims, and much more!

Immediate
Did you know that most referrals and authorizations properly submitted through TriWest's secure provider website are processed automatically within minutes? Now, your patients can get the care they need faster and you can move on to the next task at hand.

Faster
No one likes to wait to get paid and with electronic claims submissions, you won't wait long! On average, 90% of "clean" claims submitted online are processed in less than five days—more than 10 days faster than submitting paper claims.

Easier
Stay up-to-date with TRICARE®! After registering online, you will automatically receive exclusive access to the West Region Benefit Lookup Tool at TriWest.com/Provider then Eligibility — an easier way to check benefits and eligibility.

Plus, you'll receive TRICARE eNews with resources and TRICARE updates, including billing, reimbursement, and benefit changes and more — all direct to your email account!

Not registered? Register today by clicking the orange "Register Now" button in the top right-hand corner of TriWest/com/Provider. To make the registration process as easy as possible, make sure you have the following information available before you register:

- Your Tax ID number
- License number, Medicare number or NPI (National Provider Identifier)
- One of the following:
    - Two claim numbers (from TRICARE West-Region Claim remittance advices)
    - Two authorization reference numbers
    - One claim number and one reference number

In addition, you will need the date of birth of the beneficiary or beneficiaries from the internal control number (ICN) or reference number.

Need help registering? If you don't have the information needed to register for the secure website, you can click on the Contact Us link at the bottom of TriWest.com or call WPS EDI at (800) 782-2680 for assistance.

Already registered? Start taking advantage of the convenient online tools available now at www.TriWest.com/Provider.

Don't Wait – Update! Check Your Information Today

Have you moved into a new office recently? Changed your telephone number? Have more missed appointments or patients arriving late for appointments?

If you answered yes to any of these questions, you need to take a minute to check your information on the TriWest Provider Directory to update your contact information. To verify your information, go towww.TriWest.com and click on *Find a Provider* at the top of the page.

If a change is necessary, please contact your Local TRICARE Representative as soon as possible with the correct information. It is important to provide your Local TRICARE Representative with demographic updates like changes in physical location, tax identification number, telephone number, claims payment address, email addresses for staff working with TRICARE, etc.

Go to www.TriWest.com/Provider and click on *Local TRICARE Representative* to find your Local TRICARE Representative.

We thank you for taking the time to verify your information and for the service you provide to TRICARE beneficiaries.

Fraud: Reminder in Regard to Correct Billing Methods

BCBSMT has always identified all covered professional providers through the use of unique, internal provider identification numbers. With the implementation of the National Provider Identification (NPI) number, the NPI has now become the primary identifier used to identify the provider who rendered services to a patient.

One of the most common complaints received on the BCBSMT fraud hotline is from patients advising us that the provider billed on their claim for benefits is not the provider who actually rendered services. The BCBSMT Special Investigations Unit (SIU) has identified the practice of submitting claims under an incorrect provider name and ID as the number one problem addressed by the unit. Because of the various differentials in provider reimbursement, a claim billed under an incorrect provider name can result in unwarranted increases in reimbursement. When identified, however, many providers justify the billing as being incident-to services. **BCBSMT, however, DOES NOT recognize incident-to billing, but requires that claims be billed under the name and NPI of the provider who actually rendered the service.**

The Centers for Medicare and Medicaid (CMS) defines incident-to services as those that are "furnished incident to physician professional services in the physician's office (whether located within a different office suite or within an organization) or in the patient's home." Incident-to billing is an allowable practice when billing Medicare. However, as previously stated, **BCBSMT DOES NOT** recognize incident-to billing.

In general, if a provider did not render a service, the claim should not be billed under that provider's name and ID. The BCBSMT Provider Manual details this requirement under the "Claims Submission" section and states, "Providers must submit claims for services under the provider number assigned to them." Submitting claims for payment under another provider's number may be considered fraud as defined under the Montana Insurance Fraud Protection Act in Montana Code Annotated 33-1-1202(1). A provider may not let another provider use their name, NPI number, or any other identifying information to submit claims except as described in the BCBSMT Locum Tenens Policy or Provider-in-Training Policy. Copies of these policies are available on the BCBSMT website (www.bcbsmt.com).

The following guidelines are being provided in an effort to end any misunderstanding regarding BCBSMT policies for billing the appropriate provider on claims submitted for benefits.

1. **In general, always bill using the name and ID of the provider who rendered the service to the patient.**
2. **Do not bill under the name and ID of a participating provider if the services were actually performed by a provider who does not participate with BCBSMT.** Nonparticipating providers are reimbursed at a different schedule than participating providers.
3. **Do not bill under the name and ID of a physician if the services were actually performed by a Physician Assistant or Nurse Practitioner.** BCBSMT has a different reimbursement schedule for mid-level providers, so services rendered by these specialties must be billed under their name and ID. Physician supervision of a mid-level is not the equivalent of rendering the actual service.
4. **Do not bill under the name and ID of a physician (or other covered professional) if the services were actually performed by a Massage Therapist.** Massage therapists are not recognized as covered providers by BCBSMT so services rendered by a Massage Therapist are not eligible for benefits when billed appropriately under their name. Note : Benefits are available for services provided by a Massage Therapist under the Federal Employees Program, which is administered by BCBSMT.
5. **Do not bill under the name and ID of a physician (or other covered professional) if the services were actually performed by any other *noncovered or nonlicensed provider*.**

The BCBSMT Internal Audit Department and Special Investigations Unit will be performing targeted audits in follow-up to this notice, so if your office has been incorrectly billing the provider of service, please contact our office immediately.

BCBSMT will work with providers who self-report and will limit the refund of any overpayment to one year from the date of this letter. Providers who fail to self-report, but are identified in the follow-up audits may be subject to a full investigation and possible legal action, subject to the Montana Insurance Fraud Protection Act.

We thank all of our providers for their efforts in following BCBSMT's billing guidelines.

If you have questions or concerns about fraud or questionable practices, call our fraud hotline at 1-800-621-0992 or you may e-mail us atfraud@bcbsmt.com. More information is also available on our website at www.stopfraud.bcbsmt.com.