

3 CLAIMS, BILLING & REIMBURSEMENT

OVERVIEW

All claims must be submitted in accordance with the requirements of the provider contract, applicable member's contract, and this Sourcebook. You may not seek payment for covered services from the member, except for any applicable visit fees, co-payments, deductibles, coinsurance, or penalties as described in the member's contract.

Except for co-payments, which may be collected at the time of service or discharge, you should not bill the member for any cost-sharing amounts until he/she has received an Explanation of Benefits (EOB) from us. In no event should you require a deposit from a member prior to providing covered services to the member.

HIPAA REQUIREMENTS FOR ELECTRONIC TRANSACTIONS

The "Administrative Simplification" provisions of the Health Insurance Portability and Accountability Act (HIPAA) require that certain types of transactions among healthcare entities be conducted in a standard format when they are conducted electronically.

These transactions include:

- ASC X12N 837 – Healthcare Claim: Dental
- ASC X12N 837 – Healthcare Claim: Professional
- ASC X12N 837 – Healthcare Claim: Institutional
- ASC X12N 270/271 – Healthcare Eligibility Benefit Inquiry and Response
- ASC X12N 278 – Healthcare Services Review: Request for Review and Response
- ASC X12N 276/277 – Healthcare Claim Status Request and Response

- ASC X12N 834 – Benefit Enrollment and Maintenance
- ASC X12N 835 – Healthcare Claim Payment/Advice
- ASC X12N 820 – Payroll Deduction and Other Group Premium Payment for Insurance Products

Electronic claims must be submitted using the X12 837 version 4010A electronic transaction format. Empire's companion document and guides are located on our website www.empireblue.com. Click on the "Facilities" tab, then "HIPAA" and then "Institutional Bulletins & Documents."

WEB TOOLS AND RESOURCES

Empire's Facility Online Services at our website www.empireblue.com, provides a constantly-expanding collection of features, tools and resources to assist the hospital and facility administrators and medical professionals, and ensure compliance with HIPAA requirements. To take advantage of many of the available benefits, you must be a registered user. Visit www.empireblue.com and click on the Facilities tab. Additional information is available at IES Technical Help Desk at **1-866-889-7322**, Monday – Friday, 8:30 a.m. – 4:30 p.m.

As of the publication of this Sourcebook, dated January 1, 2006, using our website you can:

- Search for claim status
- Search for Explanation of Benefits (EOB)
- Determine patient eligibility for 100% of Empire's membership
- Get real-time benefits information
- View EDI Reports on errored claims

- Submit and check status of precertification requests
- View last approved day (LAD) and discharge summaries
- Submit batch claims online
- Determine BlueCard member eligibility and claim status
- View updated Empire Plan Descriptions for group and individual plans
- Find updates on this sourcebook, which include precertification, billing procedures, medical management and more
- Find companion documents and guides for EDI and HIPAA
- Determine if a vendor or clearinghouse is HIPAA-compliant
- Access medical policies with payment rule information
- Past and present issues of *Empire News for Hospitals and Facilities*, our quarterly newsletter for institutions
- Pharmacy-related news and the most recently updated version of our formulary

Coming Soon

- Submit claims and obtain real-time claim status
- Submit appeals — reduce unnecessary phone calls
- Online Claim Correction

CLAIMS SUBMISSION REQUIREMENTS

180-Day Claims Submission Requirement

We require that you submit claims for healthcare services provided to our members within a specified time frame. We will not process or pay any claim received more than 180 days after:

- The date of service for outpatient services or
- The date of discharge for inpatient services

In the event that the hospital demonstrates to Empire that it previously could not reasonably ascertain Empire's status as a primary or secondary payor with respect to a particular claim, Empire will permit the hospital to submit its claim within sixty (60) calendar days after the hospital ascertains Empire's status. In addition, you may not bill our members for any

covered services that were not received by us within this 180-day period. In the event of a dispute, the hospital must be able to document that Empire received the claim within the 180-day time frame through return receipt (paper claims) or Empire validation reports (electronic claims).

Inpatient and Ambulatory Surgery Services Claims

The guidelines below must be followed when submitting inpatient and ambulatory services claims:

- Well-Baby newborn claims do not require authorization if there is an authorization on file for the mother
- Preadmission testing does not require a separate authorization when the related inpatient or ambulatory surgery precertification has been confirmed
- Preadmission testing claims may not be submitted until the surgery or inpatient claim has been submitted to us

Outpatient Claims

The following guidelines must be followed for all outpatient claims:

- Outpatient claims must report the patient's diagnosis in valid ICD-9-CM or CPT code format based upon the symptoms that necessitated the visit. Compliance with these procedures will expedite claims and reduce requests for medical records. Additionally, ICD-9-CM and CPT codes that are described as not otherwise specified (NOS) or not otherwise classified (NOC) should not be used.
- Any claim submitted without the required coding or information outlined above will be rejected.

Outpatient CPT Claims

For those providers who have contracted for **outpatient** CPT processing, we will process (based on individual contract with facility) outpatient diagnostic, therapy, home infusion and ambulatory surgery claims based on CPT codes that are billed in conjunction with revenue codes based on the Empire CPT-4 crosswalk. The crosswalk, which maps CPT-4 or HCPCs to the appropriate Revenue Codes, is available upon request. Claims which do not utilize this coding will be rejected and will need to be resubmitted with the appropriate coding combination.

CPT outpatient ambulatory surgery claims will be reimbursed based on the revenue code and CPT surgical procedure code. We will reimburse multiple

CPT surgical procedure codes. Empire does not accept Modifier 50 for claims processing, so bilateral procedures reported with the same CPT/HCPCS must be billed on separate lines using an LT/RT Modifier. The highest rate category will be reimbursed at 100% of the rate, the second highest at 50% of the rate, and all subsequent categories will be reimbursed at 25% of the rate.

Medicare crossover claims are excluded from the CPT payment methodology, as we reimburse Medicare balances only.

Payment Adjustments

The process of reducing future payments by the amount that was adjusted or overpaid is called “negatively adjusting the facility’s account.” This is done by systematically retracting a claim payment and placing a “negative balance” on the facility’s account. The EOB will show a minus sign next to the “Payment” column. When this occurs, the overpayment should be removed from the account(s) in question and used to credit the other accounts paid on the remittance advice.

A large retraction may not be satisfied on one EOB. Occasionally, a negative balance will carry over to future EOBs. When this occurs, the EOB will show claim payments but no check will be issued. The total amount paid will appear at the end of the EOB in the “Net Amount Paid” field.

The “Adjustment from Previous Balance” field will indicate how much money from the previous retraction should be used to satisfy the accounts that appear on this EOB. The original retraction will not be shown on each individual EOB; it will appear only on the EOB from which it was originally taken.

It is very important to keep track of the original retraction so that all of the accounts involved may be correctly credited.

You should contact Provider Services with any questions about payment adjustments. Please have the following information ready before calling:

- Your facility’s tax identification number
- Your six-digit Medicare provider number or your Empire provider number
- The member’s identification number
- The patient’s name, date of birth, date of service and claim number (if available)

This information will help to expedite your request. Provider Services is available at **1-800-992-2583**, Monday – Friday, 8:30 am – 5:00 pm.

Late Charges

If you are billing for late charges to an already adjudicated claim, you must use X12 837 version 4010A electronic transaction format. For inpatient claims, the original room charges must be reported with Type of Bill 115. For outpatient claims, just the late charges must be reported with Type of Bill 135.

Corrected Bills

If you are billing a corrected claim you must use the X12 837 version 4010A electronic transaction format when submitting the request for a corrected bill. For inpatient claims, submit with Type of Bill 117. For outpatient claims, submit with Type of Bill 137.

CLAIM REIMBURSEMENT POLICIES

Reimbursement for services that physicians, hospitals and healthcare facilities provide to Empire members is based upon the contracts that Empire has with its providers and its members, and Empire’s reimbursement guidelines. To help you understand how your claims are reimbursed, the following are explanations of Empire’s reimbursement guidelines.

When has an admission occurred?

An admission is considered to occur:

- When a patient is registered as an inpatient in the hospital,
- Is determined to require medically necessary inpatient services, and
- Remains as an inpatient at the hospital past midnight of the date the patient is registered as an inpatient

If the hospital decides to keep an ambulatory surgery patient past midnight for observation, the overnight stay will not be considered an admission, unless there were complications that required an inpatient level of care.

A new inpatient day begins at midnight each day. If a patient is admitted on Monday and discharged on Tuesday, hospitals reimbursed on a per diem basis will be paid the per diem for one (1) day (because the patient stayed past midnight on Monday). This is true regardless of when the patient is discharged on Tuesday, whether 9:00 a.m. or 11:59 p.m. Per diems are not paid for the date of discharge. If a patient is discharged, dies, or is transferred on the same date as the patient is admitted, an inpatient day has not occurred.

Readmissions

In the event of a readmission of a Covered Person by the hospital, only the more expensive admission will be reimbursed. A “readmission” occurs when, within three (3) days following a Covered Person’s discharge from the hospital, the Covered Person is admitted to the hospital again for the same diagnosis (or a closely related diagnosis) that was the subject of the first admission, and pursuant to generally accepted standards of medical care, it is determined that the readmission was for a relapse of the same condition as the first admission, or was due to insufficient stabilization of the patient’s condition prior to discharge.

In no event will Empire pay for an admission to remedy care rendered on the first admission that was in some way grossly deficient or negligent (e.g., wrong side surgery, patient given overdose of chemotherapy, etc).

Transfers

Empire’s Medical Management Department must approve all transfers. Empire does not approve transfers between acute facilities unless the transfer is considered to be medically necessary. When a transfer is approved, reimbursement to the transferring and accepting facilities will be apportioned so as to avoid duplicate payment, according to a methodology mutually agreed upon by Empire and the hospital.

Calculating the Member’s Payment Responsibility

Any coinsurance payable by the member will be based on the lesser of the amount payable pursuant to the hospital’s negotiated rates with Empire or the hospital’s actual charge for the covered service, and any rate add-ons required by law. Empire will deduct from its payments to the hospital any amount the member is required to pay as a visit fee, co-payment, coinsurance, deductible or penalty. If Empire is primary, Empire will then pay the balance of the applicable rate set forth in the hospital’s participation agreement. For example, if the hospital’s charges are \$800, but the negotiated rate is \$1,000, and the member’s coinsurance responsibility is 80%, the member’s coinsurance payment will be \$640 (80% of the lesser number of \$800). Empire will then pay the hospital \$360 (after subtracting the member’s payment of \$640 from the negotiated rate of \$1,000).

Pool Payments

Empire has elected to pay directly to the pool administrator all bad debt, charity care and graduate medical education amounts due under New York State’s Health Care Reform Act (“HCRA”).

Reimbursement for Outpatient Laboratory Services

All Empire members enrolled in HMO-based products must be directed to a laboratory or hospital that participates in the QuestNet laboratory network. Empire will not pay any claims for referred ambulatory diagnostic laboratory services provided to such members by a laboratory that does not participate in the QuestNet Laboratory network. Balance billing of the member will not be permitted.

If a member enrolled in an Empire HMO-based product requests to have lab services rendered at your hospital, and your facility is not participating in the QuestNet network, you must advise the member of your out-of-network status and have the member sign a waiver indicating that he/she accepts full financial responsibility for payment of those services. Only then will you be able to bill the member for diagnostic lab services.

Note: Presurgical and preadmission testing are not required to be performed by a QuestNet laboratory or hospital. Hospitals will continue to be reimbursed for such services in accordance with the terms of their participation agreement with Empire.

Medically Necessary Care

Empire BlueCross BlueShield will reimburse for medically necessary services when the care is:

- Consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury
- In accordance with standards of good medical practice
- Not solely for the convenience of the patient or the provider
- Not primarily custodial
- The most appropriate supply or level of service that can be safely provided

Cosmetic and Reconstructive Surgery

Cosmetic surgery is not a covered service because it is performed to reshape the structure of the body in order to alter the appearance or to alter the manifestation of the aging process. Reconstructive surgery is covered when it is performed to improve or restore bodily function or to correct a functional defect resulting from disease, trauma, or congenital or developmental anomalies. When surgery is done for both cosmetic and reconstructive purposes, the allowed amount will be prorated based on the percent of the surgery that was reconstructive in nature. However, breast reconstruction

following mastectomy for cancer is not considered cosmetic. This includes surgery on the contralateral breast for symmetry.

Based on an examination of claims and records, Empire has identified diagnoses which will be regarded as cosmetic and suspended for records review when they are removed, ablated or injected, including epidermal inclusion or pilar cyst, fibroma, keloid scar, lipoma, papilloma, seborrheic keratosis and skin tags.

The physician may submit medical records for review, demonstrating the medical necessity for the removal of the lesion, including pruritis, infection, bleeding, inflammation, recurrent trauma and suspicion of malignancy. Upon demonstration of medical necessity, such claims will be paid.

Investigational Procedures or Treatment

1. There are some procedures that may be considered investigational for certain clinical indications or situations. If Empire has identified that a procedure has some merit for specific uses or if the procedure has already been mentioned in a specific policy statement, the procedure will not appear in this document. Procedures appearing on the E&I list in Appendix 1 are considered investigational and will be denied.
2. When a drug approved by the FDA for treatment of one type of cancer is prescribed for another type of cancer, the drug will be covered when it is “recognized” or “recommended” for treatment of the type of cancer for which the drug has been prescribed in the Association of Community Cancer Centers Compendia for treatment of the second type of cancer.
3. Experimental/Investigational means that the technology, in comparison to standard treatments or services, is:
 - Not of proven benefit, according to controlled studies in the peer-reviewed medical literature, for the particular diagnosis or treatment of the covered person’s particular condition; or
 - Not generally recognized by the medical community, as reflected in the published peer-reviewed medical literature, as effective or appropriate for the particular diagnosis or treatment.
4. We will not cover any technology or hospitalization in connection with the technology if, in our sole discretion, the technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment.
5. Appeals of denials for experimental procedures would be considered pending submission of peer-reviewed medical literature by the requesting physician.

See Appendix 1 at the back of this Sourcebook to view the E & I list. Please note this list is not all-inclusive — there may be some procedures not on the list which Empire considers to be E & I.

General Coding and DRG Validation Review

Empire has contracted with independent, experienced healthcare evaluation and quality improvement organizations to perform a diagnostic related group (DRG) validation review on negotiated case rates. Audits on payments are a part of your Participation Agreement with Empire.

The reviewers will select cases for review. They will review the medical records with facility staff to validate each coding and DRG assignment. All information obtained from the review will be kept confidential and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations.

Our contracted reviewers may request to review records at your site or off-site. We ask that you accommodate both requests. The vendors will perform their evaluations with minimal disruption to the hospital staff while performing an on-site review.

The vendors will notify you of the outcome of the review. If a reviewer identifies an overpayment to your facility for any reviewed DRG, Empire will make appropriate adjustments to the payments. If the reviewer is unable to review the records, Empire will make adjustments to payments based upon the information available to us at that time. Any adverse determination will be subject to the appeal rights specified in your contract.

As of this printing, Empire’s contracted reviewer(s) include:

- Meridian Resource Company

Other reviewer(s) used by Empire customers include:

- MedReview Inc., a subsidiary of New York County Health Services Review Organization