Update on the Affordable Care Act: Grace Periods

The Affordable Care Act (ACA) includes a provision that allows health insurance marketplace enrollees who receive the advance premium tax credit (APTC), a three-month grace period to pay their premium—provided they have already paid at least one month’s premium in full. It is important to note that not all members who purchase coverage on the health insurance marketplace will receive the APTC.

The provision requires all payers to process claims (for covered services rendered) in the first month of the grace period. For covered services rendered during months two and three, payers must either pay or pend claims.

During the three-month grace period, members are eligible for covered services under their plan, however, payers are not obligated to pay claims for the second or third month of the grace period unless and until the member has paid all outstanding premiums.

**ELIGIBILITY**

You will be notified through electronic and phone eligibility and benefits verification when a member has entered into a grace period during the last two months of the grace period. All benefit preauthorization letters will encourage providers to confirm whether the member is in a grace period.

**CLAIMS PROCESSING**

All allowable services provided during the first month of the grace period will be the responsibility of Blue Cross and Blue Shield of Illinois (BCBSIL), subject to member cost sharing.

During the second and third months of the grace period, BCBSIL will pend the claims with dates of service during this period. If the member pays all outstanding premium payment(s) in full, claims incurred during this period will process according to the member’s benefits.

If the member has not paid premiums in full by the end of the grace period, BCBSIL will terminate the member’s policy retroactive to the first day of month two of the grace period. BCBSIL will deny any claims for dates of service in months two and three of the grace period.

**PHARMACY CLAIMS**

A member’s pharmacy claims will be denied during months two and three. If the member retroactively pays the premium in full, they may submit claims for prescriptions dispensed during this time to BCBSIL.

If a member elects to receive a 90-day supply of a prescription during month one of the grace period, the member will receive the full 90-day prescription and BCBSIL will pay this claim.

**PROVIDER CONTRACT REQUIREMENT**

Your contract with BCBSIL requires the provision of services to members and prohibits advance payment for such covered services except for member’s required cost sharing, if any. You may notify your patients that they will be responsible for payment for the full cost of provided services, up to billed charges, if their health care coverage terminates at the end of the grace period. You can encourage your patients to make their premium payments to avoid termination of their health insurance policies.

Note: provider implications of the ACA grace period will not begin until March 2014.

**MEMBER ENGAGEMENT**

Over the next few months, BCBSIL will implement an educational campaign directed at new members. This campaign will help them fully understand the benefits and responsibilities of health care coverage, including a timely premium payment.

As a reminder, the terms of your network contract prevent you from refusing to provide services to a BCBSIL member, irrespective of where they purchased their coverage.

Look for more information about the grace period in future editions of the Blue Review.
Administrative Simplification Updates, Reminders and Resources

BCBSIL has updated its systems and business processes for the Administrative Simplification Phase III Operating Rules for 835 Electronic Funds Transfer (EFT) and 835 Electronic Remittance Advice (ERA), as mandated under the ACA. The 835 EFT/ERA operating rules were authored by the Committee on Operating Rules for Information Exchange (CORE), which is part of the Council for Affordable Quality Healthcare (CAQH) initiative. By increasing uniformity when exchanging health care data, the operating rules are intended to help promote greater adoption and utilization of electronic transactions.

ONLINE ENROLLMENT AVAILABLE NOW

Participation in EFT and ERA is strongly encouraged for all BCBSIL independently contracted providers. As we have outlined in many previous communications, EFT, ERA and other electronic transactions have many advantages, including greater security of your patients’ health care data, decreases paper waste and may reduce the amount of time your staff may spend on manually processing the paper version of these transactions.

If you are already enrolled for electronic payment and remittance transactions, you will not need to enroll again. However, if you have not signed up for EFT and ERA, now is the time, as the enrollment process is easier than ever. BCBSIL contracted providers who are registered with Availity® may complete the EFT and ERA electronic enrollment process online via the secure Availity provider portal. Please note that you must be a registered Availity user to complete the online enrollment process. Visit availity.com for more information.

REASSOCIATION REMINDER: CONTACT YOUR BANK

New and current EFT and ERA users should contact their financial institutions to request that the necessary data for reassociation is sent with each payment. Reassociation is a process that supports matching of payments with claim data for posting to your patient accounts. A sample letter you can customize and send to your bank is available in the CORE section of the CAQH website at http://www.caqh.org/benefits.php. (Go to Mandated Operating Rules then select EFT and ERA. Scroll down to the Implementation Resources section and look for the Sample Provider EFT Reassociation Data Request Letter link.) This document includes instructions to assist you with requesting delivery of the reassociation data, as well as a glossary of key terms.

FOR MORE INFORMATION

For general information about Administrative Simplification, along with BCBSIL-specific resources, please visit the Administrative Simplification page in the Standards and Requirements/Affordable Care Act (ACA) section of our website at bcbsil.com/provider. Articles also may be included in upcoming issues of the Blue Review, as well as the News and Updates section of our Provider website.

For additional information regarding the Administrative Simplification operating rules, you should refer to the CAQH CORE website at http://www.caqh.org/CORE_rules.php. As indicated on the site, any questions not addressed by CAQH CORE online resources may be directed to CORE@caqh.org.

CAQH CORE is a multi-stakeholder collaboration of more than 130 organizations representing providers, health plans, vendors, government agencies and standard-setting bodies developing operating rules to help simplify health care administrative transactions. For additional information, refer to the CORE section of the CAQH website at http://www.caqh.org/benefits.php.

Availity is a registered trademark of Availity, LLC. Availity is a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services offered by independent third party vendors. If you have any questions about the products or services offered by such vendors, you should contact the vendors directly.
Accurate Completion of Service Location and Rendering NPI Information on Professional Claims

BCBSIL’s Special Investigations Department (SID) has identified that the service location and rendering NPI information on some professional electronic (837P) and paper (CMS-1500) claims submitted to BCBSIL is inaccurate and/or incomplete.

INFORMATION FOR ELECTRONIC CLAIM SUBMITTERS

Here are some important reminders to assist you and your software vendor, billing service or clearinghouse, if applicable, when submitting professional electronic (837P) claims to BCBSIL:

• The Service Facility Location Name (along with the “XX” qualifier and NPI) is required when it is different from the billing location. The street address, city, state and nine-digit ZIP code also must be included. This information is required in Loop 2310C, as follows:

   NM1*77*2*FACILITY NAME*****XX*NPI 10 DIGIT #~
   N3*123 MAIN STREET~
   N4*CITY*STATE*123456789~

• The Rendering Provider Name (along with the "XX" qualifier and NPI) is required at the claim level when it is different from the Billing Provider Name. The Provider Specialty Information should also be included, along with the appropriate taxonomy code. This information is required in Loop 2310B, as follows:

   NM1*82*1*SMITH*JOHN*A***XX*NPI 10 DIGIT #~
   PRV*PE*PXC*PROVIDER’S TAXONOMY CODE~

INFORMATION FOR PAPER CLAIM SUBMITTERS

On professional paper claims, the servicing provider location should be included for the Service Facility Location (field 32) and the rendering or performing provider NPI should be included for the Rendering Provider ID # (field 24j, shaded). For resources to assist you with proper completion of the CMS-1500, refer to the Paper Claim Submission User Guides in the Education and Reference Center/Tutorials and User Guides section of our website at bcbsil.com/provider. Also visit the National Uniform Claim Committee website at nucc.org for additional information about the CMS-1500 claim form.

FRAUD AWARENESS RESOURCES

We welcome you to view our SID Fraud Awareness Tutorial, available in the Education and Reference Center/Fraud and Abuse section of our Provider website. This section of our website also includes an online form to report potential fraud and related concerns. Or, call our Provider Fraud Hotline at 877-272-9741. Calls can be anonymous.

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ICD-10 Resource Guide Now Available Online

Later this year, all HIPAA-covered entities will be required to transition from using ICD-9 codes to using ICD-10 codes. The transition requires careful planning for practices of all sizes to meet the Oct. 1, 2014, implementation deadline. BCBSIL has created an online resource guide to help providers prepare for the transition.

The resource guide, available on the ICD-10 page of the Standards and Requirements section on our website at bcbsil.com/provider, contains information and many resources to help your practice get ready for ICD-10.

Learn about:

• The benefits of being prepared
• Financial implications of ICD-10
• Training and education resources
• Industry and government guides

In addition to the resource guide, continue to read the Blue Review throughout 2014, for information about ICD-10. More ICD-10 topics can be found in previous issues of the Blue Review, available online in the News and Updates section of the Provider website.
In an effort to comply with fairness in contracting legislation and keep our independently contracted providers informed, BCBSIL has designated a column in the Blue Review to notify you of any significant changes to the physician fee schedules. Be sure to review this area each month.

Effective March 1, 2014, select immunizations, vaccines and toxoids in the 90281-90396 and 90476-90748 Current Procedural Technology (CPT®) code ranges will be updated. Please note that not all CPT codes in this range will be affected.

The information above is not intended to be an exhaustive listing of all the changes. Annual and quarterly fee schedule updates can also be requested by using the Fee Schedule Request Form. Specific code changes that are listed above can also be obtained by downloading the Fee Schedule Request Form and specifically requesting the updates on the codes listed in the Blue Review. The form is available in the Education and Reference Center/Forms section of our Provider website at bcbsil.com/provider.

CPT copyright 2012 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

A Closer Look: Documentation and Coding for Diabetes Diagnoses

In last month’s Blue Review, we took a closer look at documentation and coding for pulmonary diagnoses as part of our effort to provide more information that may help with the transition to ICD-10, Risk Adjustment and more. This month, we look at diabetes, a group of metabolic diseases that includes chronic and short-term conditions such as diabetes mellitus, gestational diabetes and impaired glucose tolerance. The conditions that fall under this category can sometimes be asymptomatic and other times can develop complications. It is important that documentation is specific and accurate to facilitate accurate, complete and compliant diagnosis code assignment.

On Oct. 1, 2014, the health care industry will transition from ICD-9-CM to ICD-10-CM/PCS for diagnoses and inpatient procedure coding. It is essential to take note of the key differences in coding in ICD-9-CM versus the ICD-10-CM/PCS code sets. The goal of this article is to review documentation and diagnosis coding for conditions that fall under the diabetes umbrella to achieve accurate and compliant practices.

**DIABETES MELLITUS**

Diabetes mellitus (DM) is a disease in which the body fails to properly produce or use insulin. Diabetes mellitus is divided into two categories: Type 1, insulin-dependent DM (IDDM), previously referred to as “juvenile diabetes,” and Type 2, non-insulin-dependent DM (NIDDM), previously referred to as “adult-onset diabetes.”

ICD-9-CM code structure classifies diabetes into a single code category, 250. Accurate code assignment required determination of specific fourth- and fifth-digit sub-classifications. The fourth digit provides details regarding the presence of manifestations or complications due to diabetes, while the fifth digit indicates whether the diabetes is controlled or uncontrolled, Type 1 or Type 2. The fourth-digit sub-classifications are:

- **250.0**, diabetes mellitus without mention of complication
- **250.1**, diabetes with ketoacidosis
- **250.2**, diabetes with hyperosmolarity
- **250.3**, diabetes with other coma
- **250.4**, diabetes with renal manifestations
- **250.5**, diabetes with ophthalmic manifestations
- **250.6**, diabetes with neurological manifestations
- **250.7**, diabetes with peripheral circulatory disorders
- **250.8**, diabetes with other specified manifestations
- **250.9**, diabetes with unspecified complication

The fifth-digit sub-classifications are:

- **0** for Type 2 or unspecified type, not stated as uncontrolled
- **1** for Type 1 (juvenile type), not stated as uncontrolled
- **2** for Type 2 or unspecified type, uncontrolled
- **3** for Type 1 (juvenile type), uncontrolled

Note that codes 250.4, 250.5, 250.6, 250.7 and 250.8 all include instructions to use an additional code to identify manifestations as diabetic.

(continued on p. 5)
ICD-10-CM requires an additional layer of specificity which requires providers to document additional information, such as any underlying condition that caused the diabetes or whether the diabetes is drug induced. In ICD-10-CM, the categories of diabetes mellitus will help identify the type of diabetes. Those categories are:

- E08, diabetes mellitus due to underlying condition
- E09, drug or chemical induced diabetes mellitus
- E10, Type 1 diabetes mellitus
- E11, Type 2 diabetes mellitus
- E13, other specified diabetes mellitus

ICD-10-CM does not require specification of whether the condition is controlled versus uncontrolled. ICD-10-CM classifies inadequately controlled, out-of-control and poorly controlled diabetes mellitus by type with hyperglycemia. ICD-10-CM codes for diabetes are combination codes that include the etiology and the manifestations. Assignment of codes should include as many codes needed to describe all the associated complications that the patient has. Due to the code structure, there is no instructional note found under diabetes codes in ICD-10-CM requiring an additional code to identify the manifestation since it is already part of the code description. Specific diabetes codes require additional codes in order to identify the manifestation further, such as diabetes with foot ulcer to identify the site of the ulcer, or diabetes with chronic kidney disease to identify the stage of chronic kidney disease. In ICD-10-CM, it is important to review the coding guidelines and notes in each category. In particular there is one note available in each category, except for Type 1 diabetes. This note states: “Use additional code to identify insulin use (Z79.4).” This code would not be assigned with Type 1 cases because insulin is required to sustain life.

SECONDARY DIABETES

If the diabetes is secondary, choose from codes in the 249 series in ICD-9-CM.

In ICD-10-CM, secondary diabetes is coded as diabetes due to an underlying condition (E08), drug or chemical induced diabetes (E09) or other types of secondary diabetes not otherwise classified (E13), which includes diabetes due to genetic defects of beta-cell function or insulin action and postsurgical cases of diabetes. With this depth of detail, providers must document the cause of secondary diabetes in order to correctly select a diagnosis code. The cause of the secondary diabetes is sequenced first, followed by the code for the diabetes.

GESTATIONAL DIABETES

Gestational (pregnancy induced) diabetes can occur during the second and third trimester of pregnancy in women who were not diabetic prior to pregnancy. It puts the woman at greater risk of developing diabetes after the pregnancy. In ICD-9-CM, report 648.0, diabetes mellitus complicating pregnancy, childbirth and the puerperium. ICD-10-CM codes for gestational diabetes are in subcategory 024.4, gestational diabetes. No other code from category O24 should be used with a code from 024.4. The codes under subcategory 024.4 include diet controlled and insulin controlled. Postpartum diabetes can occur and if a patient with gestational DM is treated with both diet and insulin, use only the code for insulin controlled. Code Z79.4, long-term (current) use of insulin, should not be assigned with codes from subcategory 024. An abnormal glucose tolerance in pregnancy is assigned a code from subcategory 099.81, abnormal glucose complicating pregnancy, childbirth and the puerperium.

There are many new codes for diabetes as well as the complications from diabetes. Providers will be required to identify a causal link between the type of diabetes and the complications. Clear, concise, complete documentation will be critical to help ensure accurate and compliant coding.
### NEW ACCOUNT GROUPS

**iEXCHANGE® Adds Behavioral Health Requests for Intensive Outpatient Program**

As we announced in the January Blue Review, iEXCHANGE, our Web-based benefit preauthorization tool, has been enhanced to support behavioral health benefit preauthorization requests that fall under the intensive outpatient program.

iEXCHANGE allows providers to submit both behavioral health and medical/surgical preauthorization requests electronically 24 hours a day, 7 days a week.*

The expanded iEXCHANGE capabilities offer an alternative to the manual fax process that is currently in place for these benefit preauthorization requests and help reduce the need to initiate calls to providers regarding missing information and/or request status.

The added behavioral health requests will be supported by the real-time capabilities currently provided for medical/surgical transactions, including:

- Select outpatient services
- Extension requests
- Treatment searches
- Treatment update searches

After submitting a request using iEXCHANGE, you will receive an immediate confirmation with details on the request. Once processed, you will either receive a determination that the authorization pended for review or is approved. Users also will receive a Request ID number as reference for each preauthorization request.

**Learn More**

Webinars have been scheduled during the month of February to introduce the new system enhancements. To register for an iEXCHANGE webinar, visit the Workshops and Webinars page in the Education and Reference Center section of our Provider website and select your preferred training session.

*With the exception of every third Sunday of the month from 11 a.m. to 2 p.m.

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**NOTE:** Some of the accounts listed above may be new additions to BCBSIL; some accounts may already be established, but may be adding member groups or products. The information noted above is current as of the date of publication; however, BCBSIL reserves the right to amend this information at any time without notice. The fact that a group is included on this list is not a guarantee of payment or that any individuals employed by any of the listed groups, or their dependents, will be eligible for benefits. Benefit coverage is subject to the terms and conditions set forth in the member’s certificate of coverage.
Provider Learning Opportunities

**BCBSIL WEBINARS AND WORKSHOPS**
Below is a list of complimentary training sessions sponsored by BCBSIL. For details and online registration, visit the Workshops/Webinars page in the Education and Reference Center of our website at bcbsil.com/provider.

### WEBINARS

**CRT Webinars**  
Learn more about our user-friendly, enhanced claim status tool that offers status of multiple claims in one view and expanded search options.  
Weekly webinars are being offered through February and March 2014.  
Visit our website for exact dates and times.

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**Electronic Refund Management (eRM)**

Feb. 26, 2014  
All sessions: 10 to 11 a.m.

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**iEXCHANGE Webinars**  
Session for Staff – Medical/Surgical/Pharmacy

Feb. 26, 2014  
All sessions: 10 to 11 a.m.

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**iEXCHANGE Webinars**  
Session for Clinical Staff – Medical/Surgical/Pharmacy

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**iEXCHANGE Webinars**  
Session for Administrative Training

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**Spring BCBSIL Medicare Advantage Roundtable**

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**Spring BCBSIL HMO Managed Care Roundtable**

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**Are you submitting professional paper claims? You may need to take action!**

As a reminder, payers began accepting the revised version of the CMS-1500 paper claim form (version 02/12) as of Jan. 6, 2014. According to the transition timeline announced by the National Uniform Claim Committee (NUCC), payers will accept claims submitted on either the revised form (02/12) or the previous version (08/05) through March 31, 2014. After this date, the dual-use period will end and payers will receive and process only those claims that are submitted on the revised CMS-1500 claim form (version 02/12). Paper claims submitted on the old form on or after April 1, 2014, will be rejected.

As part of the transition, you may need to:

- **Order new paper claim forms** – Refer to the NUCC website at nucc.org for details.
- **Talk with your vendor(s)** – Is your software vendor, billing service or clearinghouse prepared to accommodate changes?
- **Consider switching to electronic claim submission** – Visit the Claims and Eligibility/Claim Submission section of our website at bcbsil.com/provider to learn more.
Coming March 2014: New Fax Process for Length of Stay Extension Requests

Effective March 3, 2014, BCBSIL will implement a new fax process for receipt of clinical information from hospitals to support length of stay extension requests for BCBSIL PPO members. This implementation follows completion of a successful pilot with select Illinois hospitals, conducted in third quarter 2013, to evaluate potential efficiencies.

Test users responded favorably, as pilot results yielded:

- Improved response times by BCBSIL to service requests
- Decreased phone calls for both providers and BCBSIL
- Receipt of more comprehensive clinical information

Please note that there are no changes to the current process for notification of inpatient acute hospital admissions, which may be completed online through iEXCHANGE, or by phone. Once the new fax process is implemented on March 3, 2014, length of stay extension requests may be initiated prior to the last approved day by faxing the necessary clinical information to BCBSIL at 312-946-3985.

Your assigned Provider Network Consultant may be contacting you with additional details regarding the new fax process for length of stay extension requests. Also watch for a follow-up article in an upcoming issue of the Blue Review.