Claim Frequency Codes Accepted on Professional Claims
How to Submit an Electronic Replacement or Voided Claim

The Blue Cross and Blue Shield of Illinois (BCBSIL) claim system was recently enhanced to accept the claim frequency code on professional electronic claims (ANSI 837P transactions). Using the appropriate code will indicate that the claim is an adjustment of a previously adjudicated (approved or denied) claim.

The claim frequency codes are as follows:

<table>
<thead>
<tr>
<th>Frequency Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Indicates the claim is an original claim</td>
</tr>
<tr>
<td>7</td>
<td>Indicates the new claim is a replacement or corrected claim. The information present on this bill represents a complete replacement of the previously issued bill.</td>
</tr>
<tr>
<td>8</td>
<td>Indicates the claim is a voided/canceled claim</td>
</tr>
</tbody>
</table>

**REPLACEMENT CLAIMS**

Replacement claims submitted electronically will reduce the potential for a claim to deny as a duplicate. If a replacement claim needs to be submitted, you may submit the correction electronically with the appropriate frequency code (7). **Claims with modifier 25 and 59 corrections are excluded from this process and may not be submitted electronically.**

An example of the ANSI 837P file containing a replacement claim, along with the required REF segment andQualifier in Loop ID 2300 – Claim Information, is provided below.

**Claim Frequency Code**

```
CLM*12345678*500***11::7*Y*A*Y*I*P~
REF*F8*(Enter the Claim Original Reference Number)
```

The first two digits (“11”) in the example above indicate the place of service on a professional claim. The colons (“::”) between the place of service and frequency code are known as Sub-element Separators (indicates that this field is currently not used).

The replacement claim will replace the entire previously processed claim. Therefore, when submitting a correction, send the claim with all changes exactly how the claim should be processed.

**Examples:**

1. A claim was previously submitted with procedure codes 99213, 88003 and 77090. The 88003 should have been 88004. An electronic replacement claim should be submitted for the line that needs to be corrected, along with the appropriate frequency code: 7, 99213, 88004 and 77090. This indicates to BCBSIL that all charges need to be deleted, and the claim will then be processed with 99213, 88004 and 77090.

2. A claim was previously submitted with procedure codes 99214, 70052 and 99213. Procedure codes 70052 and 99213 were submitted in error and need to be removed. An electronic replacement claim should be submitted with frequency code 7 and procedure code 99214. This claim will then be adjusted to remove 70052 and 99213, and it will be processed with 99214.

*(continued on page 5)*
National Drug Codes (NDCs) Required on Professional Claims

National Drug Code (NDC) pricing has been fully implemented by BCBSIL for all professional claims with dates of service on or after Sept. 1, 2011. If you submit professional claims to BCBSIL for any medications, you must include the NDC and related information (qualifier, unit of measure, number of units, and price per unit). You must also include the applicable Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT®) code(s). Professional claims that are submitted without NDCs and all required information will not be accepted.

THIS MONTH’S BILLING EXAMPLE: J0894
To help illustrate use of NDCs and related information, we will continue to provide examples of high-volume J codes, and how they “translate” in terms of billing for drugs on professional claims.

What was administered?
In our sample scenario, a patient receives decitabine 50 mg.

What’s on the package label?
The NDC is found on the medication’s packaging. The drug’s container label may display less than 11 NDC digits. An asterisk may appear in either a product code or a package code as a place holder for any leading zeroes. Each container label displays the appropriate unit of measure for that drug.

Decitabine is supplied as a lyophilized powder in a single-dose, 50 mg/vial. Here is an example of the NDC information that you may see when you are preparing to bill: 62856-0600-01 Dacogen, 50mg SOLR Unit of Measure = UN

What to include on the claim:
When entered on your claim, the NDC must follow the 5digit-4digit-2digit format—any leading zeroes must be added to each segment to make 11 digits total. The NDC must be in the proper format (11 numeric characters, no spaces or special characters)

For our sample scenario:
• The NDC is 62856-0600-01 (the qualifier is N4)
• The unit of measure is UN, since the drug came in a vial in powder form and had to be reconstituted
• The quantity (number of NDC units administered) is 1
• The quantity (number of J-code units administered) is 50
• The price per unit also must be included*

For more information regarding proper submission of valid NDCs and related information on your electronic (ANSI 837P) and paper (CMS-1500) claims, see the NDC Billing Guidelines for Professional Claims on page 3.

*To obtain NDC pricing information, please use the appropriate Fee Schedule Request Form, available in the Education and Reference Center/Forms section of our Provider website at bcbsil.com/provider.

Note: Reimbursement for discarded drugs applies only to single use vials. Multi-use vials are not subject to payment for discarded amounts of the drug.

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NDC Billing Guidelines for Professional Claims

Here are some guidelines for appropriate submission of valid NDCs and related information on professional electronic and paper claims:

- Submit the NDC along with the applicable HCPCS or CPT code(s)
- The NDC must be in the proper format (11 numeric characters, no spaces or special characters)
- The NDC must be active for the date of service
- The appropriate qualifier, unit of measure, number of units, and price per unit also must be included, as indicated below

**ELECTRONIC CLAIM GUIDELINES (ANSI 837P)**

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Field Description</th>
<th>ANSI (Loop 2410) – Ref Desc</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product ID Qualifier</td>
<td>Enter N4 in this field.</td>
<td>LIN02</td>
</tr>
<tr>
<td>National Drug CD</td>
<td>Enter the 11-digit NDC (without hyphens or spaces) assigned to the drug administered.</td>
<td>LIN03</td>
</tr>
<tr>
<td>Drug Unit Price</td>
<td>Enter the charge per unit of the product, service, commodity, etc.</td>
<td>CTP03</td>
</tr>
<tr>
<td>NDC Units</td>
<td>Enter the quantity (number of units) for the prescription drug.</td>
<td>CTP04</td>
</tr>
<tr>
<td>NDC Unit/MEAS</td>
<td>Enter the unit of measure of the prescription drug given. [Values: F2 – international unit; GR – gram (powder); ML – milliliter (liquid); UN – unit (tablets)]</td>
<td>CTP05-1</td>
</tr>
</tbody>
</table>

If you have any questions regarding electronic claim submission, contact our Electronic Commerce Center at (800) 746-4614.

**PAPER CLAIM GUIDELINES (CMS-1500)**

In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left-justified), immediately followed by the NDC. Next, enter the appropriate qualifier for the correct dispensing unit (F2 – international unit; GR – gram (powder); ML – milliliter (liquid); UN – unit (tablets)); followed by the quantity and the price per unit, as indicated in the example below. (The HCPCS/CPT code corresponding to the NDC is entered in field 24D.)

**Example:**

```
N400173044202   ML2 12.82
J2405          1  1  1
25  4
```

For additional paper claim details, refer to the National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual, available on the NUCC website at nucc.org.

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 changes to the physician fee schedules. Be sure to review this area each month.

**Effective Aug. 15, 2011, the following codes were updated:** 90655-90657, 90662 and Q2038.

NDC pricing has been implemented for all professional claims with dates of service on or after Sept. 1, 2011. To obtain NDC pricing information, please use the appropriate Fee Schedule Request Form, available in the Education and Reference Center/Forms section of our Provider website at bcbsil.com/provider.

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.
Be Smart. Be Well.®
Videos Featured at Sprout Film Festival

Two videos featured on the Be Smart. Be Well. website (besmartbewell.com) recently received international recognition. The videos, created for the Be Smart. Be Well. traumatic brain injury topic, were chosen for screening at the 2011 Sprout Film Festival in New York. The festival showcases films about people with developmental disabilities. The screening marked the first time the festival has shown films on traumatic brain injury.

These videos were created to raise awareness of what the Centers for Disease Control calls one of the least diagnosed conditions in the U.S. They spotlight struggles of two men, Jerry and Josh, and how each man’s life was permanently changed by a traumatic brain injury.

“The Sprout Film Festival showcases films featuring people with a variety of developmental disabilities to give an accurate portrayal of the issues facing this population,” says Anthony Di Salvo, the festival’s executive director. “By presenting films of artistry and intellect, the festival strives to create an enjoyable and enlightening experience that will help break down stereotypes and promote a greater acceptance of differences and awareness of similarities.”

Videos containing health-related topics recently featured on Be Smart. Be Well. are now available, including issues that address childhood obesity, mental health, drug safety, domestic violence and more. Each DVD contains all of the videos related to that specific health topic. The list of topics is also available on the site at besmartbewell.com.

If you are interested in obtaining one or multiple of these videos on DVD for your practice, please send an email to Susan Zimny at susan@besmartbewell.com, or contact your assigned Provider Network Consultant.

BCBSIL launched Be Smart. Be Well. in 2007 to serve as a free, non-commercial public service site to raise awareness of prevalent, yet largely preventable, health and safety issues affecting the communities we serve. We urge you to visit besmartbewell.com today, and we invite you to share the site with your patients, peers and employees.

ANSI Version 5010: Make it Work for your Practice
Are you ready to generate new standard transaction formats?

The new HIPAA electronic transaction standard, ANSI Version 5010 (ANSI v5010), will be the only transaction version that will be accepted by BCBSIL and other payers beginning Jan. 1, 2012. All covered entities* will be impacted, including hospitals and physician practices. Assessing your readiness and the readiness of all of your vendors is critical. This includes successful completion of the testing of ANSI v5010 transactions prior to the Jan. 1, 2012, implementation date.

If your practice management/hospital information system and (if applicable) your billing entity (billing service and/or clearinghouse) are unable to support ANSI v5010 transactions on Jan. 1, 2012, your electronic claims (ANSI 837 transactions) will be rejected. Other HIPAA-standard Electronic Data Interchange (EDI) transactions, such as eligibility and benefits (ANSI 270), claim status (ANSI 276), and the Electronic Remittance Advice (ANSI 835 ERA) will also be affected, as these transactions must conform with the new ANSI v5010 standard transaction format as well.

Note: Practice management/hospital information system software developers and vendors are not required to be HIPAA compliant. It is your responsibility to contact your software vendor to confirm that your system is running the most current, HIPAA-compliant software.

WHO IS YOUR PRIMARY CONTACT?

Many providers may utilize a billing service and/or clearinghouse to handle their health care transactions, such as claims. Who has been assigned the task of getting your claims “out the door” and on their way to BCBSIL? Do you know if all of your claims are sent electronically? Do you know if your vendor ever “drops” your claims to paper for submission to BCBSIL?

If your billing service is your primary contact, and if you have not done so already, you should start a dialogue with them about ANSI v5010 readiness. Ask them what they have done to meet the mandated requirements of ANSI v5010, and ask what they need from you to help ensure you will be in compliance. You send your claims data to them—where do they send it?

By knowing your primary contact, and by becoming aware of the additional contacts and the exact route your transactions take from your office to your payers, you will have a distinct advantage in managing any issues and resolving any problems.

KNOW WHERE YOUR CLAIMS GO!

Many providers believe that their claims are submitted directly to BCBSIL. Actually, only a small number of claims are directly submitted to us. Almost all claims go through intermediaries before arriving at BCBSIL. An intermediary could include one or more of the following:

- A practice management system (PMS) or hospital information system (HIS)
- A billing service
- One or multiple clearinghouses

Since a claim may be handled by multiple entities along its way to us, there is a potential for processing delays at each of these points. At each point of contact, the transaction must be validated before it can move on to the next point of contact. A transaction can only progress to the next entity if it meets all requirements—including all new claim submission mandates, such as those related to the use of the National Provider Identifier (NPI) and changes to Billing Provider Address/Loop 2010AA requirements.

If it meets all of the format and data requirements, the transaction is forwarded to our primary claims clearinghouse where it is subjected again to format and data validation. If the transaction passes this point of review, it makes its way to BCBSIL. Failure to pass the validation requirements will result in rejection, sending the transaction back through each step to the point of orig...

(continued next page)
ARE THEY EVEN GOING TO BECOME COMPLIANT?

After a claim leaves your office, it should not become “out of sight, out of mind.” Follow up with your primary contact. They should be confirming receipt of all transactions, and whether or not those transactions were passed successfully on to the next entity. If your primary contact has not been keeping you in the loop, start asking questions for each transaction.

• Did your primary contact receive a successful report back?
• If the claim was rejected at the next connection point, ask why, or “Where are my response reports?”
• Were rejections/errors fixed to enable the transaction to continue on its way?
• Is each intermediary entity along the way getting ready for the conversion to ANSI v5010? Is each entity testing now? When will each entity be fully compliant?

Get involved in your own claim process. ANSI v5010 is coming, and you need to test now to help ensure that your claims are being processed. Make your primary contact accountable. Make sure you and your staff are trained and ready.

FOR MORE INFORMATION

Visit the ANSI v5010/ICD-10 page in the Standards and Requirements section of our website at bcbsil.com/provider where you can:

• View preparation tips and timeline reminders
• Find links to helpful resources on other sites, such as the Centers for Medicare and Medicaid Services (CMS)
• View answers to frequently asked questions

Need assistance? Email your ANSI v5010/ICD-10 questions to us at ansi_icd@bcbsil.com.

* Covered entities include health plans, clearinghouses, health information trading partners, health information networks and health care providers who transmit HIPAA transactions electronically.

The above information is for educational purposes and is not legal advice. If you have any questions regarding compliance with the various laws or regulations, you should consult with your legal advisor.

Claim Frequency Codes Accepted on Professional Claims

How to Submit an Electronic Replacement or Voided Claim

(continued from page 1)

Note: If a charge was left off the original claim, please submit the additional charge with all of the previous charges as a replacement claim using frequency code 7. All charges for the same date of service should be filed on a single claim.

*Corrected claims using modifiers 25 or 59 must be submitted on paper, along with medical records. For these requests, use the Claim Review Form, which is available in the Education and Reference Center/Forms/Post-Claim Processing Requests section of our website at bcbsil.com/provider.

VOID CLAIMS

If a claim was submitted to BCBSIL in error and needs to be voided, the claim to be voided should be submitted exactly as it was submitted previously, along with the appropriate frequency code to indicate that the claim should be voided (8).

If you have any questions regarding the above notification, please contact our Electronic Commerce Center at (800) 746-4614.

New ‘Texting and Driving eCard’ Sends Powerful Safety Message

In 2009 we launched eCards for HealthSM, an online greeting card program, designed to encourage people to commit to small, healthy behavior changes and share their commitments with those they care about.

Providers, members and the general public can visit ecardsforhealth.com for inspiration to make small, manageable steps toward improving their overall health. This site includes eCards covering a variety of healthy behavior suggestions, such as:

• Cutting down on sweets
• Walking more
• Reducing stress
• Scheduling an annual physical exam

This month we’re pleased to introduce the Texting and Driving eCard. Cell phone use is one of the most common forms of distracted driving. According to the National Highway Traffic Safety Administration website, nhtsa.gov, an alarming 28 percent of traffic accidents are now caused by people talking on cell phones or sending text messages while driving. There’s no safe way to text and drive, so it’s vital to be aware and give driving your undivided attention.

You can help call attention to this important issue by sending the new Texting and Driving eCard, and encouraging your patients to do the same. Just visit eCards for Health at ecardsforhealth.com to view the latest eCards and Wellness Screen Savers available for personal use. Senders will also receive tips related to healthy change and links for more wellness information.

Remember, this site is not only for BCBSIL members, but is made available to the general public. So tell all of your patients to check out eCards for Health to start making positive lifestyle changes.
How the BlueCard® Program Works

BlueCard is a national program that enables members of one Blue Cross and Blue Shield (BCBS) Plan to obtain health care services while traveling or living in another BCBS Plan’s service area. The program links independently contracted participating health care providers with the independent BCBS Plans across the country, and in more than 200 countries and territories worldwide, through an electronic network for claims processing and reimbursement.

Example:
A member has PPO coverage through Blue Cross and Blue Shield of Michigan (BCBSM) and is traveling in Illinois, or resides in Illinois but has employer-provided coverage through BCBSM, and needs to receive health care services.

In either scenario, the member can obtain the names and contact information for PPO providers in Illinois by calling the BlueCard Access Line at (800) 810-BLUE. The member also can obtain information online by using the Provider Finder® on our website at bcbsil.com, or by using the BlueCard National Doctor and Hospital Finder on the Blue Cross and Blue Shield Association website at bcbs.com. (*Note: Members are not obligated to identify participating providers through any of these methods, but it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits.)*

When the member makes an appointment to see you, an Illinois PPO provider, you may verify the member’s eligibility and coverage via an electronic eligibility and benefits request (ANSI 276) through your preferred third party vendor portal. You may also obtain this information by calling the BlueCard Eligibility Line at (800) 676-BLUE.

After rendering services, file your claim electronically with BCBSIL. We will forward the claim internally to BCBSM to adjudicate the claim according to the member’s benefits and your reimbursement agreement with BCBSIL. When the claim is finalized, the Michigan Plan issues an explanation of benefits or EOB to the member, and BCBSIL issues the Electronic Payment Summary (EPS) or Provider Claim Summary (PCS) and payment to you.

For additional information, refer to the BlueCard Program Manual, located in the Standards and Requirements section of our website at bcbsil.com/provider.
Medicare Part D Pharmacy Updates:

Second Quarter 2011 Formulary Changes

The Pharmacy Program/Medicare Part D Updates section of our website at bcsil.com/provider includes articles that are intended to help keep you up-to-date on Medicare Part D issues such as formulary changes, U.S. Food and Drug Administration (FDA) safety updates, Part D Gap strategies, overlapping coverage between Part B and Part D drugs, and more.

Last month, we added the Second Quarter 2011, Medicare Part D Formulary Updates to our online library. This article includes a summary table of some of the more important BCBSIL Medicare Part D Formulary changes that may be of interest to you.

In addition to viewing a summary of recent formulary changes on the BCBSIL website, you may follow the instructions below to visit Prime Therapeutics’ “MyPrime” website for a complete listing, along with other Medicare Part D formulary information for your BCBSIL patients.

1. Go to www.myprime.com
2. Click on Find Drugs & Estimates
3. Under “Select Your Health Plan,” choose BCBS Illinois from the dropdown menu
4. Under “Medicare Part D Member,” select Yes
5. Under “Select Your Health Plan Type,” select BlueMedicareRx (PDP)
6. Conduct a search by individual drug name, or scroll down to view Forms & Related Information (e.g., Comprehensive Formulary, Formulary Updates, Prior Authorization Criteria/Form, How to File a Grievance, Evidence of Coverage, Transition Policies, and more)

Prime Therapeutics LLC is a third party pharmacy benefit management company. BCBSIL contracts with Prime Therapeutics to provide pharmacy benefit management and other related services. BCBSIL, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics LLC.

Medicare Supplement Benefit Matrices on the Web

Each year, BCBSIL posts updated Medicare Supplement Benefit Matrices on our website. To view the updated 2011 matrices, visit the Tutorials/User Guides section of our online Education and Reference Center at bcsil.com/provider. Four years of archived information is also available on our website for reference purposes.
Each month the Blue Review includes information to help you and your staff stay up-to-date on the latest BCBSIL initiatives, including product news, electronic connectivity enhancements, claim submission reminders, new account groups, webinar/workshop topics for independently contracted BCBSIL providers, and more!

Many Blue Review articles may also relate to billing entity processes. If you utilize a billing service, clearinghouse or software vendor to send/receive information to/from BCBSIL on your behalf, please share this newsletter with them. Current and past issues of the Blue Review are easily accessible on our website at bcbsil.com/provider.

For contract ing Institutional and professional providers

Blue Review is a monthly newsletter published for Institutional and Professional Providers contracting with Blue Cross and Blue Shield of Illinois. We encourage you to share the content of this newsletter with your staff. Blue Review is located on our website at bcbsil.com/provider.

The editors and staff of Blue Review welcome letters to the editor. Address letters to:

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Visit our Website at bcbsil.com/provider