Ancillary Claim Filing Requirements  
FAQs for Providers

Background

Effective October 14, 2012, Anthem Blue Cross and Blue Shield (Anthem) will implement claim filing requirements, based on ancillary provider type. The requirements reflect a Blue Cross and Blue Shield Association (BCBSA) mandate and apply to the following ancillary provider types: Independent Clinical Laboratory (Lab), Durable/Home Medical Equipment and Supplies (D/HME) and Specialty Pharmacy.

The BCBSA requirements are a change for many Blue Cross and Blue Shield Plans (Plans). The requirements stipulate the correct Local Plan to process the above ancillary type claims, as follows:

- Independent Clinical Lab claims should be filed to the Plan whose service area the referring provider is located as determined by the zip code NPI.
- D/HME claims should be filed to the Plan in whose service area the equipment and/or supplies were shipped to, or the location of the retail store where the equipment and/or supplies were purchased or rented.
- Specialty Pharmacy claims should be filed to the Plan in whose service area the ordering provider is located, i.e., the address of the ordering physician.

The following information is intended to help answer ancillary provider questions on how Anthem and other Plans are managing the transition to the mandated ancillary claim filing requirements.

BCBSA Information

Why did the BCBSA mandate ancillary claim filing requirements?
The claim filing requirements are intended to streamline the process for filing the above-noted ancillary type claims for all Plans.

When did BCBSA change ancillary claim filing requirements?
Plans have been able to contract with designated ancillary providers located outside their service area since September 2004. The claim filing requirements were clarified in 2010, and all Plans must ensure they are enforcing these requirements no later than October 14, 2012.

Where does the BCBSA publish these requirements?
BCBSA shares the requirements with Plans; Plans communicate to providers. At Anthem, we’ve communicated to providers through our provider newsletters, Network Update. Additionally, this FAQ document can be found online on the provider portal at www.anthem.com. EDI also has published information on its web site at www.anthem.com/edi.

What is the timeline for Anthem Blue Cross and Blue Shield (Anthem) to implement these requirements?
Effective October 14, 2012, Anthem will implement claim filing requirements based on ancillary provider type.

Do the BCBSA claim filing requirements compel Plans to contract with any provider who requests this?
No. Speaking for Anthem, we will offer contracts to providers when there is a demonstrated access issue for the specialized services offered by that provider AND the provider meets our participation criteria.
Definitions

How is D/HME defined?
D/HME includes, but is not limited to: Hospital beds, oxygen tanks, crutches, etc.

How is Independent Clinical Lab defined?
It is any type of independent, clinical, laboratory, as defined by the Plan, that provides types of services including, but not limited to: Testing and analysis of blood, urine, tissue, etc.

How is Specialty Pharmacy defined?
Specialty pharmacy is defined as non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member’s Plan’s Specialty Pharmacy formulary. These include, but are not limited to: injectable infusion therapies, etc.

Do the ancillary claims filing requirements apply to FEP?
No. The ancillary claims filing requirements apply to all claims directly submitted to the BCBS Plan except FEP (Federal Employee Plan). FEP will continue to be outside the purview of Inter-Plan Programs. All FEP claims should be processed in accordance with the FEP claims filing requirements.

Do the ancillary claims filing requirements apply to Medicare Crossover claims?
No. Because Medicare crossover claims are crossed over and not submitted directly, they are not subject to ancillary claims filing requirements -- for now. However, if the claim includes a non-covered Medicare ancillary service or a member liability, i.e., co-pay or deductible, the provider would submit the claim to the Local Plan and the claim would be subject to the ancillary claims filing requirements:

Do the ancillary claims filing requirements apply to BlueCard® WorldWide claims?
The BlueCard Worldwide claims for medical services incurred outside the United States, Puerto Rico and U. S. Virgin Islands are not subject to the ancillary claims filing requirements. The ancillary claims filing requirements apply to claims incurred within the United States.

Do the ancillary claims filing requirements apply to hospital-based (Lab, D/HME, Specialty Pharmacy) providers?
The requirements may apply if the claim is submitted on a professional claim form by a provider whose specialty is defined in our system as Lab, D/HME, or Specialty Pharmacy.

Do the ancillary claims filing requirements apply to Medicare Advantage and Medicaid claims?
Yes.

Claims submission

Where do providers submit ancillary claims for members who divide their time between states, e.g., the member spends summers in New York and winter in Florida?
The claims need to be submitted to the Plan in accordance to the ancillary claims filing requirements listed above.

Is there a minimum timeframe a member must live at an address for it to qualify as the shipping address?
No.

How are claims to be handled when service occurs in a contiguous county?
Ancillary claims incurred in a contiguous county should be filed to the Plan in which service area the services were rendered based on the ancillary claims filing requirements listed above. With implementation of these requirements, the contiguous county claims filing rules that were in use no longer apply to D/HME, Lab and Specialty Pharmacy claims.
For claims submissions, does Anthem maintain a list of all Plan addresses across the country?
No. Providers should obtain the address for claims submission from the appropriate Plan.

How do ancillary providers ensure that they can continue to submit electronically to any Plan?
Some Independent Lab, D/HME, and Specialty Pharmacy providers, who electronically submit claims to Anthem today, will need to submit claims to other Plans based on where services were rendered or delivered. In order to avoid claims rejections, these providers should set up Trading Partner agreements with Plans with whom they don’t currently contract.

- Our contracted ancillary providers can call the EDI HelpDesk at 800-470-9630, or go to http://www.anthem.com/edi to request assistance with submitting to other Anthem Plans (CA, CO, CT, IN, KY, ME, MO, NH, NV, OH, VA, WI), Empire Blue Cross and Blue Shield and Blue Cross and Blue Shield of Georgia.
- If providers need to establish Trading Partner agreements with non-Anthem Plans, they should contact the Plans directly if they are not currently billing through a Clearinghouse.
- Clearinghouses can assist providers with setting up access for electronically billing other Plans.

Will the new requirements force providers to send attachments with every claim, so they can demonstrate that they are filing to the correct plan?
These requirements do not compel providers to submit additional attachments. Providers should continue to submit the same information that they do today.

Should Box 32 show the servicing location or corporate address?
Box 32 should include the name and address of the facility that rendered the service if it was not provided in the practitioner’s office.

When providers call the Home Plan to inquire on precert/prior-auth requirements, will the Home Plan’s representatives be aware of the impact of these changes and inquire on the expected delivery state (for D/HME) or referring/ordering provider (for Specialty Pharmacy)?
BCBSA expects ancillary providers to know where they must submit the claim and if they are a contracted provider with that Plan. If they are not contracted with that Plan, we recommend that providers ask if the member has out of network benefits and what they are.

If a claim is submitted to Anthem, and it is the wrong Local Plan, what happens?
The claim will be rejected and the provider will receive a notification that the claim must be submitted to the correct Local Plan.

Are Plans required to adjust ancillary claims processed prior to the October 14, 2012 implementation date, if the provider requests it?
Plans are not required to re-evaluate claims processed prior to October 14, 2012 to determine if they were processed according to the ancillary claims filing rules; however, a valid provider request to adjust a claim should not be denied. A valid provider request excludes adjudication based solely on the ancillary requirements.

What will happen if an ancillary provider is not contracted with the Plan to which the claim must be submitted? How will the claim be processed?
The claim will process according to that Plan’s out of network claims processing policies.

How do providers obtain a non-participating provider number for an Anthem Plan?
Providers do not need to request a non-participating provider number. When a claim is submitted with a valid NPI, Anthem will review its system to see if the provider’s NPI is on file. If it is, Anthem will process the claim based on that information. If there is no information on file, Anthem will set up a provider number and contact the provider for additional information if needed.
How do providers obtain a non-participating provider number for a non-Anthem Plan?
The provider should contact the non-Anthem plan.

Member Benefit/Member ID cards/Authorization Requirements

How will a member’s co-pay, deductible and benefits be impacted by this change?
The impact depends on whether the new claim filing requirements make a provider non-par. If the provider
remains participating with the Plan, there is no change. If the provider is now non-par, there could be a change in
the member’s cost share and out-of-network coverage.

Will Anthem add addresses for submitting Lab, D/HME, and Specialty Pharmacy claims to the member’s
insurance card?
No. ID cards will not change.

Specialty Pharmacy prescriptions and diabetic strips are often billed to the member’s Pharmacy Benefits
Manager (PBM) rather than to the Plan. Do the ancillary claim filing requirements change this?
These requirements do not change the member benefits; they merely stipulate the correct Plan for filing the
ancillary claim. As such, Specialty Pharmacy prescriptions and diabetic strips may continue to be submitted to the
PBM.

Do authorization requirements change as a result of the implementation of these claim filing
requirements?
No.

Lab specific

How will the Plan determine the referring provider if the specimen was collected by a non-physician (e.g.
Home Health Agency, Home Infusion Therapy provider)?
The expectation is that the claim form will include the referring physician’s information, not any other provider
type. The HCFA companion guide provides direction on completing field 17B.

When a claim is submitted to a Plan, will the Plan decide if the guidelines apply to that claim based solely
on the place of service (POS) being 81 (i.e., independent laboratory)?
Plans should base their decision on a combination of the POS 81 and the provider specialty of Independent
Clinical Lab.

The billing provider can only put one referring physician’s ID in box 17B of the 1500 Health Insurance
Claim Form. How can the billing provider identify in one box both who ordered the test and who obtained
the specimen?
Billing providers should follow the National Uniform Claim Committee instructions regarding how information is
populated on 1500 Health Insurance Claim Form, box 17B (Name of Referring Provider or Other Source).

D/HME specific

Does BCBSA have a CPT® code list of what it considers to be D/HME? Is this consistent across all BCBS
Plans?
The claim filing requirements are based on provider specialty, not codes.

Is the BCBSA aware of the Medicare rule that states all D/HME must be billed with the home Place of
Service (POS)?
BCBSA is aware of the Medicare rule. However, a claims submission to a Plan is different from a claim
submission to Medicare and we have never followed CMS’ guideline in this regard. For Anthem’s purposes, if
equipment is picked up in the office setting, the POS is the office. If it’s delivered to the home, the POS is home.
How will Plans determine the member’s home address? Will they use the address that they have on file for the member?
The Plan will determine the member’s address based on the information submitted by the provider.

**Provider Services**

Are Anthem’s provider and member customer service areas prepared to answer questions on the ancillary claim filing requirements?
Anthem has provided training and tools to help ensure our customer service staff is equipped to respond to provider and member inquiries.

Who can help educate providers on where to file claims?
The Provider Services team in each Plan should be equipped to respond to provider inquiries.

How can provider billing agencies be made aware of these changes?
Providers should direct their agency to the information that has been posted online at www.anthem.com, share these FAQs, and encourage the agency to tap its other resources for information and guidance. At the end of the day, those who do provider billing are responsible for understanding and complying with all claim filing requirements, including those associated with ancillary services and products.

September 2012

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