Training Documentation
Psychiatric Hospitals
2017
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1.0 INTRODUCTION

Inpatient Psychiatric Hospital claims are submitted electronically to Capital BlueCross. The following sections address Eligibility, Benefits, Billing, Reimbursement, and Quality Assessment aspects of the various programs administered by Capital BlueCross. Guidelines are provided for products offered by Capital BlueCross. Please provide all appropriate personnel with copies of these instructions.
2.0 ELIGIBILITY

Patient eligibility and benefits can be verified from the Eligibility and Benefits screen on the Capital BlueCross health plan home page via the NaviNet® portal at connect.navinet.net.

Eligibility and benefit information for Federal Employee Program® (FEP) members can be obtained through the “Out of Area Member Search” option of the Eligibility and Benefits screen.

The following information should be verified to determine eligibility and benefits:

- The contract is active at the time of service.
- The individual receiving services is an active member on the contract.

Note: Providers should document the name of the individual they spoke with at the Customer Service Call Center, the date and time that the call was made, and the telephone number that was dialed. This information should be maintained in the patient’s file for future reference.

Note: In situations where the patient was admitted and their insurance coverage changed either from Capital BlueCross to a commercial carrier or from a commercial carrier to Capital BlueCross during the course of the admission, the provider must split the charges and bill each claim to the appropriate insurer.
3.0 Benefits

Benefits for Capital BlueCross, FEP, and Keystone Health Plan® Central (KHP Central) members can be obtained by:

- Accessing the Eligibility and Benefits screen on the Capital BlueCross health plan home page via the NaviNet portal at connect.navinet.net.
- Contacting the appropriate Capital BlueCross Customer Service Call Center.

Providers with access to the Capital BlueCross health plan home page via the NaviNet portal can view an out-of-area Blue Plan’s medical policy and general precertification/Preauthorization information. This information is located in the Provider Library under two tabs titled “Out of Area Medical Policy” and “Out of Area General Precertification/Preauthorization.” These applications do not apply to either the Federal Employee Program (FEP) or Medicare Advantage members.

3.1. Federal Employee Program Benefits

Capital BlueCross processes all Federal Employee Program (FEP) member claims billed on a UB-04 from all providers within our 21-county plan area. The member’s home address is not taken into consideration when determining where to file a claim.

FEP identification numbers begin with the letter R followed by eight numbers. There is no alpha prefix.

FEP members may be enrolled for either Basic Option or Standard Option benefits. The enrollment codes for these options are:

- 111 Basic Option Self Only
- 112 Basic Option Self and Family
- 104 Standard Option Self Only
- 105 Standard Option Self and Family

Benefit, deductible, coinsurance, and reimbursement amounts differ between Basic Option and Standard Option. To review benefit and cost sharing information, either refer to the current Blue Cross and Blue Shield Service Benefit Plan handbook online at fepblue.org or contact the FEP Provider Service Telephone Unit at 1.800.344.5446.

There is no Major Medical benefit under FEP.
Coordination and medical management of mental health benefits are handled by Magellan Healthcare, Inc. This coordination applies to both inpatient admissions and outpatient services. Magellan’s toll-free number is 1.800.356.7986 and is available 24 hours a day, seven days a week.

3.2. Managed Care Programs

The Capital BlueCross POS and KHP Central programs require services to be coordinated by the Primary Care Physician (PCP) in order for services to be reimbursed at the higher level of benefit. Capital BlueCross’ contracted Inpatient Psychiatric Facilities are considered Specialty Care Providers under these Managed Care Programs.

3.2.1. The Capital BlueCross POS Program

The Capital BlueCross POS Program requires Preauthorization for behavioral health services.

3.2.2. KHP Central HMO

Verification of referrals and member benefit and copayment information is available on the Capital BlueCross health plan home page via the NaviNet portal.

3.2.3. Referral Process

POS and KHP Central do not require referrals.

Note: See Preauthorization requirements for behavioral health services.

3.2.4. Preauthorization Process

Refer to the Behavioral Health Services section of this training document.

Note: An authorization furnished by the entity that handles medical management of behavioral health is not a guarantee of payment. The member's contract must provide inpatient psychiatric benefits in order for payment to be made.

3.3. Behavioral Health Services

Verify behavioral health (mental health and substance abuse) Preauthorization requirements on the back of the member’s identification card. For many Capital BlueCross members, Clinical Management of behavioral health is handled by Magellan Healthcare, Inc. Providers may contact the appropriate Clinical Management unit directly to obtain an authorization. Clinical information will be required and must come from the treating provider.

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1 On behalf of Capital BlueCross, Magellan Healthcare, Inc. assists in the administration of behavioral health benefits. Magellan Healthcare is an independent company.
3.3.1. Behavioral Health Provider Network

The following chart gives an overview of the provider network used for each product line, the services that require Preauthorization, the telephone number to call for Preauthorization, and the address that providers should use if they are submitting hard copy claims.

<table>
<thead>
<tr>
<th>PRODUCT LINE</th>
<th>PROVIDER NETWORK</th>
<th>PREAUTH REQUIREMENTS</th>
<th>PREAUTH PHONE NUMBER</th>
<th>CLAIMS SUBMISSION ADDRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital BlueCross Programs (Traditional, Comprehensive, and PPO)</td>
<td>Capital BlueCross</td>
<td>All inpatient behavioral health services, partial hospitalization services for mental health and substance abuse conditions, and intensive outpatient programs.</td>
<td>1.866.322.1657</td>
<td>Capital BlueCross PO Box 211457 Eagan, MN 55121</td>
</tr>
<tr>
<td>Capital BlueCross POS</td>
<td>Capital BlueCross</td>
<td>All inpatient behavioral health services, partial hospitalization services for mental health and substance abuse conditions, and intensive outpatient programs.</td>
<td>1.866.322.1657</td>
<td>Capital BlueCross PO Box 211457 Eagan, MN 55121</td>
</tr>
<tr>
<td>FEP</td>
<td>Capital BlueCross</td>
<td>All inpatient behavioral health services and intensive outpatient programs.</td>
<td>1.800.356.7986</td>
<td>Capital BlueCross PO Box 211457 Eagan, MN 55121</td>
</tr>
<tr>
<td>KHP Central HMO</td>
<td>Capital BlueCross</td>
<td>All inpatient behavioral health services, partial hospitalization services for mental health and substance abuse conditions, and intensive outpatient programs.</td>
<td>1.800.216.9748</td>
<td>Capital BlueCross PO Box 211457 Eagan, MN 55121</td>
</tr>
<tr>
<td>BlueJourney HMO</td>
<td>Magellan Healthcare, Inc.</td>
<td>Contact Magellan for this information.</td>
<td>Contact Magellan for this information.</td>
<td>Contact Magellan for this information.</td>
</tr>
<tr>
<td>BlueJourney PPO</td>
<td>Magellan Healthcare, Inc.</td>
<td>Contact Magellan for this information.</td>
<td>Contact Magellan for this information.</td>
<td>Contact Magellan for this information.</td>
</tr>
</tbody>
</table>

Key aspects of Magellan’s outpatient clinical management model:

- Providers will not generally be required to obtain Preauthorization for routine outpatient care.
- Preauthorization may be required for specialty care, such as psychological testing, rTMS, hypnotherapy, ABA, and biofeedback (when these are covered by the applicable plan) when these services appear on the Preauthorization list.
- This model applies to traditional outpatient services only and does not apply to other levels of care (such as inpatient, residential, partial hospitalization programs, or intensive outpatient programs).
When a case is triggered for care management due to an atypical frequency or utilization pattern (as identified by the claims algorithms), a Magellan care advocate will reach out to the provider to collaborate in identifying barriers to treatment progress and resolution. It is vital that responses to the care advocate outreach are timely to avoid claims denials due to lack of information on these outlier cases.

**Providers submitting hard copy claims** to Capital BlueCross may also fax their claims to the following fax numbers:

- Local: **717.541.3702**
- Toll-free: **1.866.682.2242**

### 3.3.2. Exchange of Inpatient Mental Health Visits for Outpatient Days

Members of some groups have thirty (30) inpatient days/sixty (60) outpatient visits available to them during the benefit period stated in their Certificate of Coverage for the treatment of serious mental illnesses. Serious mental illnesses are schizophrenia, bipolar disorder, obsessive-compulsive disorder, major depressive disorder, panic disorder, anorexia nervosa, bulimia nervosa, schizo-affective disorder, and delusional disorder. If they have or will exhaust their sixty (60) outpatient visit limit, they have the ability to exchange each unused inpatient day for two (2) outpatient visits. The maximum exchange allowed is thirty (30) inpatient days for an additional sixty (60) outpatient visits. If members exchange one (1) inpatient day for two (2) outpatient visits, the inpatient day will no longer be available for them to use either as an inpatient day or as two (2) partial psychiatric days during the benefit period. If members exchange an inpatient day for outpatient visits, they will still be responsible for any deductible and/or copays which apply to the psychiatric outpatient visits.

If the member chooses to exchange benefits, any inpatient mental health days used in the exchange will no longer be available during the benefit period. The authorization form must be completed, signed, and dated by the member. Providers should not encourage members to fill out a form until an exchange is needed. The form allows the member to state for which benefit period they want to exchange the days. If applicable, the member will need to complete a new form for each benefit period. This is not a guarantee of payment. All requests are subject to the terms and conditions of the member’s Certificate of Coverage, including benefit limitations and medical necessity.

**Note:** This information does not apply to KHP Central HMO members. Providers should contact Magellan for guidance on the BlueJourney HMO and BlueJourney PPO programs.
# 4.0 Billing Instructions

## 4.1. UB-04 Claim Form Requirements

### UB-04 Claim Form: All Lines of Business

<table>
<thead>
<tr>
<th>KEY</th>
<th>Description</th>
<th>Inpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Required</td>
<td>R*</td>
</tr>
<tr>
<td>IA</td>
<td>Use if Appropriate</td>
<td>R</td>
</tr>
<tr>
<td>D</td>
<td>Desired</td>
<td>R</td>
</tr>
<tr>
<td>NR</td>
<td>Not Required</td>
<td>NR</td>
</tr>
<tr>
<td>*</td>
<td>See Special Requirements</td>
<td>*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Locator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locator 1</td>
<td>Billing Provider Name, Address, and Telephone Number</td>
</tr>
<tr>
<td>Locator 3a</td>
<td>Patient Control Number</td>
</tr>
<tr>
<td>Locator 3b</td>
<td>Medical/Health Record Number</td>
</tr>
<tr>
<td>Locator 4</td>
<td>Type of Bill</td>
</tr>
<tr>
<td>Locator 5</td>
<td>Federal Tax Number</td>
</tr>
<tr>
<td>Locator 6</td>
<td>Statement Covers Period (From–Through)</td>
</tr>
<tr>
<td>Locator 8a</td>
<td>Patient Name/Identifier</td>
</tr>
<tr>
<td>Locator 8b</td>
<td>Patient Name/Identifier</td>
</tr>
<tr>
<td>Locator 9</td>
<td>Patient Address</td>
</tr>
<tr>
<td>Locator 10</td>
<td>Patient Birth Date</td>
</tr>
<tr>
<td>Locator 11</td>
<td>Patient Sex</td>
</tr>
<tr>
<td>Locator 12</td>
<td>Admission/Start of Care Date</td>
</tr>
<tr>
<td>Locator 13</td>
<td>Admission Hour</td>
</tr>
<tr>
<td>Locator 14</td>
<td>Priority (Type) of Admission or Visit</td>
</tr>
<tr>
<td>Locator 15</td>
<td>Point of Origin for Admission or Visit</td>
</tr>
<tr>
<td>Locator 16</td>
<td>Discharge Hour</td>
</tr>
<tr>
<td>Locator 17</td>
<td>Patient Discharge Status</td>
</tr>
<tr>
<td>Locators 18–28</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>Locator 29</td>
<td>Accident State</td>
</tr>
<tr>
<td>Locators 31–34</td>
<td>Occurrence Codes and Dates</td>
</tr>
<tr>
<td>Locators 35–36</td>
<td>Occurrence Span Code and Dates</td>
</tr>
<tr>
<td>Locator 38</td>
<td>Responsible Party Name and Address (Claim Addressee)</td>
</tr>
<tr>
<td>Locators 39–41</td>
<td>Value Codes and Amounts</td>
</tr>
<tr>
<td>Locator 42</td>
<td>Revenue Codes</td>
</tr>
<tr>
<td>Locator 43</td>
<td>Revenue Description/IDE Number/Medicaid Drug Rebate</td>
</tr>
<tr>
<td>Locator 44</td>
<td>HCPCS/Accommodation Rates/HIPPS Rate Codes</td>
</tr>
<tr>
<td>Locator 45</td>
<td>Service Date</td>
</tr>
<tr>
<td>Locator 46</td>
<td>Units of Service</td>
</tr>
<tr>
<td>Locator 47</td>
<td>Total Charges</td>
</tr>
<tr>
<td>Locator 50</td>
<td>Payer Name</td>
</tr>
</tbody>
</table>

* R = Required, IA = Use if Appropriate, D = Desired, NR = Not Required, * = See Special Requirements.
## UB-04 Claim Form: All Lines of Business

**KEY:**
- **R** = Required
- **IA** = Use if Appropriate
- **D** = Desired
- **NR** = Not Required
- *** = See Special Requirements

<table>
<thead>
<tr>
<th>LOCATOR</th>
<th>DESCRIPTION</th>
<th>INPATIENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locator 51</td>
<td>Health Plan Identification Number</td>
<td>R*</td>
</tr>
<tr>
<td>Locator 52</td>
<td>Release of Information Certification Indicator</td>
<td>R</td>
</tr>
<tr>
<td>Locator 53</td>
<td>Assignment of Benefits Certification Indicator</td>
<td>R</td>
</tr>
<tr>
<td>Locator 54</td>
<td>Prior Payments—Payer</td>
<td>IA</td>
</tr>
<tr>
<td>Locator 56</td>
<td>National Provider Identifier—Billing Provider</td>
<td>R*</td>
</tr>
<tr>
<td>Locator 58</td>
<td>Insured’s Name</td>
<td>R</td>
</tr>
<tr>
<td>Locator 59</td>
<td>Patient’s Relationship to Insured</td>
<td>R</td>
</tr>
<tr>
<td>Locator 60</td>
<td>Insured’s Unique Identifier</td>
<td>R*</td>
</tr>
<tr>
<td>Locator 61</td>
<td>Insured’s Group Name</td>
<td>IA*</td>
</tr>
<tr>
<td>Locator 62</td>
<td>Insured’s Group Number</td>
<td>IA*</td>
</tr>
<tr>
<td>Locator 63</td>
<td>Authorization Code/Referral Number</td>
<td>IA*</td>
</tr>
<tr>
<td>Locator 66</td>
<td>Diagnosis and Procedure Code Qualifier (ICD Version Indicator)</td>
<td>R</td>
</tr>
<tr>
<td>Locator 67</td>
<td>Principle Diagnosis Code and Present on Admission Indicator</td>
<td>NR</td>
</tr>
<tr>
<td>Locators 67 A–Q</td>
<td>Other Diagnosis Codes and Present on Admission Indicator</td>
<td>IA</td>
</tr>
<tr>
<td>Locator 69</td>
<td>Admitting Diagnosis Code</td>
<td>R</td>
</tr>
<tr>
<td>Locators 72 a–c</td>
<td>External Cause of Injury (ECI) Code and Present on Admission Indicator</td>
<td>IA</td>
</tr>
<tr>
<td>Locator 74</td>
<td>Principal Procedure Code and Date</td>
<td>IA</td>
</tr>
<tr>
<td>Locators 74 a–e</td>
<td>Other Procedure Codes and Dates</td>
<td>IA</td>
</tr>
<tr>
<td>Locator 76</td>
<td>Attending Provider Name and Identifiers</td>
<td>R*</td>
</tr>
<tr>
<td>Locator 77</td>
<td>Operating Physician Name and Identifiers</td>
<td>IA</td>
</tr>
<tr>
<td>Locator 80</td>
<td>Remarks Field</td>
<td>IA</td>
</tr>
<tr>
<td>Locator 81</td>
<td>Code-Code Field</td>
<td>IA</td>
</tr>
</tbody>
</table>
4.2. Special Requirements

**Locator 1** (Billing Provider Name, Address, and Telephone Number) The billing provider address must be reported as a street address. Claims reporting a Post Office (PO) Box will be rejected on the submitter’s Accept/Reject (AR) Report. Also, the nine-digit ZIP Code is required.

**Locator 6** (Statement Covers Period [From–Through]) The “from” and “through” date format is MMDDCCYY.

FEP claims that span calendar years should be billed on one claim. The charges no longer need to be split. Benefits will be applied based on those in effect on the date that services began.

**Locators 31–34** (Occurrence Codes and Dates) The code and associated date defining a significant event relating to this bill that may affect payment.

The Occurrence Date format for electronic and hard-copy submission is MMDDCCYY. If there are more Occurrence Codes than there are spaces available, use Locator 80 (Remarks) for recording.

Occurrence Codes 01–06 (Accident Related Codes) are used if the Priority (Type) of Visit (Locator 14) is coded with a number 1 (Emergency).

When Occurrence Code 41 (Date of First Test for Preadmission Testing) is used, Locators 39–41 (Value Codes) must have code 30 (preadmission testing) and the dollar amount entered.

**Locators 39–41** (Value Codes and Amounts) If more than one value code and dollar amount are shown for a billing period, record codes in ascending numeric order. Do not enter decimal points when recording dollar amounts.

When Value Code 30 (Preadmission Testing) is used, Locators 31–34 Occurrence Codes and Dates) must have Occurrence Code 41 (Date of First Test) entered.

Value Code 80 (Covered Days) Total covered days must always equal the total units associated with Revenue Code 0001. For inpatient claims, covered days exclude the date of discharge or death.
Providers should follow appropriate procedures for reporting the Claim Level Adjustments of other payers when submitting Capital BlueCross secondary or tertiary claims. If submitting charges on a paper claim, it is permissible to use Value Codes A1, A2, A7, B1, B2, B7, C1, C2, and C7. If claims are submitted through the Capital BlueCross health plan home page via the NaviNet portal UB-04 Direct Data Entry (DDE), use the fields for Claim Level Adjustments for the primary payer (or secondary payer) on the Other Insurance Information screens. For questions from providers who submit using ANSI 837, contact your Capital BlueCross Provider Automation Service Consultant.

**Locator 42** (Revenue Codes) Record the revenue code(s) that represent the services rendered.

- 0001 Total charges (This revenue code must be included on every bill when submitting paper claims.)

**Locator 44** (HCPCS/Accommodation Rates/HIPPS Rate Codes) Room rates are required on inpatient claims.

**Locator 46** (Units of Service) The Revenue Codes for private and semiprivate rooms require units to be recorded:

The Units/Days entered beside Revenue Code 0001 must be the same as the number of covered days entered in Value Code 80, which is entered in Locators 39–41.

**Locator 50** (A, B, and C) Enter the Payer Name. If multiple, please enter in primacy order.

**Locator 51** (A, B, and C) (Health Plan Identification Number, payer codes) When Capital BlueCross or FEP is the destination payer, enter plan code 361 in the appropriate primacy order. The primary payer would be entered in A, secondary in field B, and tertiary reflected in C. If the payer is another Blue Cross plan and the three-digit identifier is available to you, that can be entered or use Capital BlueCross’ plan code 361. In situations where there are multiple Blue Plans, please use code B3 in replacement of the plan code to indicate the Blue Plan you are not expecting payment from. For all other payers you may use the code provided by the National Association of Insurance Commissioners (NAIC).

**Locator 56** (National Provider Identifier—Billing Provider) Enter the billing provider’s NPI.
Locator 60 (A, B, and C) (Insured’s Unique Identifier) The first through the third characters of the identification number should be the alpha prefix. The alpha prefix should be obtained from the member’s ID card. FEP identification numbers do not include an alpha prefix. When there is no alpha prefix on an ID card for an out-of-area member, the claim should be filed directly to the member’s Blue Plan.

   If the member’s identification number includes a two-digit suffix, include the suffix in this locator.

Locator 61 (A, B, and C) (Insured’s Group Name) Enter the group name of the primary insured in 61A, group name of the secondary insured in 61B, and the group name of the tertiary insured in 61C.

   Providing applicable information in this locator will expedite processing of COB claims.

Locator 62 (A, B, and C) (Insured’s Group Number) FEP claims should not have a group number recorded in this locator.

Locator 63 (A, B, and C) (Authorization Code/Referral Number) This is required if the member’s benefits include Preauthorization. When applicable, use this locator to record the Preauthorization number.

Locator 76 (Attending Physician ID) The license number of the physician who would be expected to certify medical necessity or be responsible for the patient’s treatment.

   Enter the provider’s NPI.

4.3. **Hard Copy Claim Submission Addresses**

Send all hard copy claims for Capital BlueCross programs, FEP, and KHP Central HMO to:

   Capital BlueCross  
   PO Box 211457  
   Eagan, MN  55121

Claims for members enrolled in one of the products offered by Capital BlueCross may also be submitted to one of the following fax numbers:

   Local:  **717.541.3702**
   
   Toll-free:  **1.866.682.2242**

Claims for BlueJourney HMO and BlueJourney PPO members must be submitted to Magellan Healthcare, Inc.
Supporting documentation for workers’ compensation and motor vehicle (automobile) claims can be submitted to the following address or fax number. Use this address and fax number only when the claim has already been filed and the supporting documentation needs to be forwarded to Capital BlueCross:

Capital BlueCross  
Harrisburg, PA 17177-5523

Fax: **1.800.929.0557**

When sending the documentation by fax, include a cover letter addressed to Other Party Liability.
5.0 CLAIM STATUS AND REIMBURSEMENT

5.1. Claim Status

To assist providers with obtaining the status of a claim, Capital BlueCross offers the ability to conduct searches on the Claim Status screen on the Capital BlueCross health plan home page via the NaviNet portal at connect.navinet.net. The following options are available on this screen: Claim Status Inquiry and Research Claim.

The Claim Status Inquiry function is used to submit inquiries on local and out-of-area claims processed by Capital BlueCross. This includes both Institutional (UB-04) and Professional (CMS 1500) claims.

The Research Claim application allows providers to submit claims-related questions regarding a particular claim that may have incorrectly paid or denied. This application should not be used to submit claims adjustments. The following are some examples of questions for which providers could utilize the Research Claim function:

- Status of Coordination of Benefits (COB) forms
- Status of adjustment requests
- Status of medical record reviews
- Status of appeals
- Status of claims pending for more than 30 days

5.1.1. “Claims Rejected to Member Due to No Coverage” Report

If a patient is no longer enrolled with Capital BlueCross, but had coverage at one time, the patient’s claims will be processed and an Explanation of Benefits (EOB) indicating no coverage will be sent to the former subscriber. Since the patient’s coverage with Capital BlueCross is no longer effective, the claim will not appear on the provider Statement of Remittance (SOR). Instead, participating providers will be forwarded a “Claims Rejected to Member Due to No Coverage” Report. This report will list any claims for which the member is no longer a Capital BlueCross enrollee. Providers will receive this report on a weekly basis.

Note: Claims for patients who were never enrolled with Capital BlueCross will not appear on this report. If Capital BlueCross receives a claim for a patient who was never a Capital BlueCross member, the claim will not be processed, and it will be returned to the provider.
5.2. Appeals

Providers may submit claims appeals for all Capital BlueCross products to the following address:

Capital BlueCross
PO Box 779518
Harrisburg, PA 17177-9518

Appeals should contain the patient name, alpha prefix, identification number, date(s) of service, claim number, and the reason for the appeal.

Timely Filing for Appeals

Unless specifically varied in and as governed by state and federal regulations (e.g., Pennsylvania’s Act 68 of 1998 [Act 68], and the Department of Labor’s Employee Retirement Income Security Act [ERISA] claims regulations), all facility provider appeals must be submitted to Capital BlueCross within one year of the original Capital BlueCross processed date of the claim that is being appealed.

Medicare timely filing guidelines on appeals apply to members covered by BlueJourney HMO or BlueJourney PPO.

Note: Some subscriber groups may have specific timely filing guidelines or requirements in their contracts with Capital BlueCross and would not be subject to the timely filing guidelines noted as above for appeals.

Additional information regarding the appeal process can be found in Chapter 25 (Dispute Resolution and Provider Appeals) of the Capital BlueCross and Keystone Health Plan Central Provider Manual.

5.3. Reimbursement

Claims will be reimbursed according to the benefits in effect under the member’s contract at the time services are rendered and the provisions of the Capital BlueCross member Inpatient Psychiatric Facility Agreement.

According to the Capital BlueCross member Inpatient Psychiatric Facility Agreement, reimbursement shall cover all services related to the member’s Inpatient Psychiatric Facility admission including preadmission testing and services provided under arrangement by other suppliers while the member is an inpatient of the member Inpatient Psychiatric Facility.
Services under arrangement would include services such as:

- Ambulance transport from your facility to and from another facility that is providing a service on your behalf.
- Services provided by another facility such as another hospital or a freestanding MRI while the patient is still an inpatient in your facility.

Services provided under arrangement while the patient is an inpatient in your facility should be included on your inpatient bill and it is your responsibility to reimburse the provider of that service.
6.0 CLINICAL MANAGEMENT

6.1. Preauthorization

Verify behavioral health Preauthorization requirements on the back of the member’s identification card.

When a provider fails to obtain the required Preauthorization for a specified service, the entire claim containing that service will be denied for failure to obtain Preauthorization.

All inpatient admissions require Preauthorization; therefore, the Preauthorization requirement applies to all services on the inpatient claim. If an inpatient claim denies for failure to obtain Preauthorization, the provider may not submit a claim adjustment to remove charges on the inpatient claim.

6.2. Request for Medical Records

When a provider receives a request for medical records, the information should be forwarded to Medical Claims Review at the following address:

Medical Claims Review
Capital BlueCross
PO Box 778995
Harrisburg, PA  17177-8995

Medical records may also be faxed to either 717.541.3702 (local) or to 1.866.682.2242 (out-of-area).

A cover sheet should be attached to the medical records that show the patient name, alpha prefix, identification number, date(s) of service, claim number, and the reason that medical records are being sent.
7.0 Facility Audits/Request for Medical Records

Capital BlueCross or its designee may request medical records at any time for any purpose, including without limitation, to make a determination related to a submitted claim or to investigate a potential quality of care issue. Medical record reviews may also be performed as necessary to assess, for example, member complaints and compliance with quality improvement activities. Capital BlueCross will provide a list of medical records needed for review and the purpose of the audit. A Corrective Action Plan may be initiated if deficiencies are identified. When requested, the facility should submit medical records to the address or fax number identified on the Capital BlueCross medical information request form.