

INSIDE **ipp**

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Medicare Advantage overview

The Medicare Advantage program is an alternative to Original Medicare Part A and Part B fee-for-service coverage. This program offers people who are Medicare-eligible several product options, including Health Maintenance Organization/Point-of-Service (HMO/POS), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS), Special Needs Plans (SNPs), and Medicare Medical Savings Accounts (MSAs). Blue Cross® and Blue Shield® plans offer many Medicare Advantage products, allowing providers to render services to Independence Blue Cross (IBC) Medicare Advantage members as well as to Medicare Advantage members from other Blue Plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and Part B benefits, and they may also offer additional benefits. For example, many Medicare Advantage plans offer Medicare prescription drug coverage for their members under the Medicare Part D benefit program.

Medicare Advantage plans also offer out-of-network benefits, depending on the type of product. For instance,

Medicare Advantage HMO plans typically require members to obtain health care services through in-network providers, except in urgent or emergency care situations or for end-stage renal disease (ESRD) services. By contrast, Medicare Advantage PPO plans allow members to use out-of-network providers. As a result, coverage for out-of-network claims may vary depending on the Medicare Advantage product type and plan selected by the member. Providers should confirm the level of coverage for all Medicare Advantage members prior to providing service.

Types of Medicare Advantage plans

Medicare Advantage HMO

A Medicare Advantage HMO product is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. A Medicare Advantage HMO member typically chooses a primary care physician (PCP) within the Medicare Advantage HMO network. In order to see an in-network specialist, the member will need to receive a referral

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Medicare Advantage overview (continued from page 1)

from his or her PCP. When referrals are required, the PCP typically decides what tests are necessary, which specialists the member should see, and whether the member should be admitted to a hospital. The PCP also may be required to obtain prior authorization from the plan for certain services. Except for urgent or emergency care situations or for ESRD services, medical services are covered only when provided by providers in the network. The level of benefits and the coverage rules may vary by Medicare Advantage plan.

Medicare Advantage POS

The Medicare Advantage POS product is a variation of the HMO product. The POS member selects a PCP, but has the option to self-refer out of network. The member may be required to obtain prior authorization for certain out-of-network services. The difference between an HMO and POS plan is that for an additional cost, the POS member may receive services outside of the plan's network and pay a higher cost-sharing.

Medicare Advantage PPO

A Medicare Advantage PPO product has a network of providers, but unlike traditional HMO products, it allows members access to services provided outside the contracted network of providers. Members usually pay a greater portion of the costs if services are obtained out of network. Medicare Advantage PPO plans may be offered on a local or regional basis. Local PPO plans refer to a network of providers in a county or multiple counties. Regional PPO plans refer to a network in the region approved by the Centers for Medicare & Medicaid Services (CMS); this region usually consists of one or more states. Special payment and other rules apply to regional PPOs.

Medicare Advantage PFFS

A Medicare Advantage PFFS product pays physicians and providers on a fee-for-service basis. Unlike PPO and HMO/POS products, PFFS plans generally do not operate with a network of contracted providers. Members may obtain services from any licensed physician or provider in the United States who is

qualified to be paid by Medicare and accepts the plan's Terms and Conditions of payment. Providers servicing (any Medicare provider can access the plan's Terms and Conditions) members can view the Terms and Conditions of any plan by using the Terms and Conditions Plan Finder on the website of the Blue Plan.

Medicare Advantage MSA

A Medicare Advantage MSA product is made up of two parts. One part is the Medicare MSA, which is a type of savings account for members to pay for qualified medical expenses. The other part is the Medicare MSA Health Policy, which is a special health insurance policy with a high deductible. Qualified medical expenses are services and products that otherwise could be deducted as medical expenses on the member's annual tax return. Those expenses include, but are not limited to, doctor visits, hospital stays, dental exams, and medical equipment. The Blue Plan calculates the amount and the Medicare program deposits the funds into the member's savings account. Savings balances accumulate interest or dividends tax free until spent; as long as the member spends the funds on qualified medical expenses, the money is tax free to the member.

Medicare Advantage SNP

A Medicare Advantage SNP product allows a Medicare Advantage organization to offer benefit plans targeted to special needs populations to limit enrollment to only members with special needs. SNP plans may enroll members who are institutionalized, dually eligible, and/or individuals with severe or disabling chronic conditions. Medicare Advantage organizations may target Medicare populations with special needs defined by the presence of certain chronic diseases. For example, a SNP may provide coverage only for members with cardiovascular disease or members who have diabetes. Unlike other Medicare Advantage Plans, SNPs must provide Medicare prescription drug coverage.

If you have any questions about the different Medicare Advantage health products, please contact your Network Coordinator. ❖

FAQ for Medicare Advantage Private Fee-for-Service

The FAQ (frequently asked questions) below provides more detailed information about Medicare Advantage Private Fee-for-Service (PFFS).

Q. What is Medicare Advantage PFFS?

A. Medicare Advantage PFFS is a health plan offered by an organization that pays physicians and providers on a fee-for-service basis. Patients may obtain services from any licensed physician or provider in the United States who is qualified to be paid by Medicare and accepts the plan's Terms and Conditions of payment. The plan must provide the same coverage under PFFS as Medicare Part A and Part B, and it may also offer additional benefits.

Q. How is the PFFS product different from other coordinated care Medicare Advantage health plans?

A. Unlike other Medicare Advantage plans, PFFS plans are not required to contract with providers to participate. Instead providers are considered to be "deemed" providers when the provider is aware that the member is covered under a PFFS health plan, accepts the plan's Terms and Conditions, and provides care to the member. If a provider does not agree to the Terms and Conditions, the provider should not provide services to the PFFS member, except in emergencies.

Q. How do I recognize Medicare Advantage PFFS members?

A. Ask the member for his or her ID card. Members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card along with the following logo:



Q. How do I verify member eligibility?

A. Use the same processes you use today to verify eligibility by calling 1-800-676-BLUE (2583) and providing the alpha prefix or submitting an electronic inquiry via NaviNet®. Be certain to verify if Medicare Advantage benefits apply.

If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to Independence Blue Cross (IBC).

Q. What are Terms and Conditions?

A. A plan's Terms and Conditions establish the rules providers must follow if they furnish services to PFFS members. At a minimum, the Terms and Conditions will specify the amount the organization will pay for covered services, billing procedures, and the amount the provider can collect from the member. PFFS organizations are required to make their Terms and Conditions of participation reasonably available to providers. Blue Plans post their Medicare Advantage PFFS Terms and Conditions on their website.

Q. How do I obtain the PFFS Terms and Conditions?

A. Instructions for viewing PFFS Terms and Conditions are on the back of the member's ID card. Terms and Conditions are posted on the website of the member's plan.

To view the Terms and Conditions for any Medicare Advantage PFFS member's plan, visit our website, www.ibx.com/providers/pffs/index.html. Select *Private Fee For Service* and then *Plan Finder*.

When using the Plan Finder:

- Enter the first three letters of the member's ID number listed on the Medicare Advantage PFFS ID card and select *Go*.
- If the first three letters of the member's ID number are XDV, please select the appropriate plan name in the drop-down box before selecting *Go*.
- Your browser will be directed to the appropriate Terms and Conditions for the member.
- If you receive an error message, please call 1-800-676-BLUE (2583).

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FAQs for Medicare Private Fee-for-Service (continued from page 3)

Q. Where do I submit claims for Medicare Advantage PFFS members?

A. Submit claims to IBC as you do for other Blue products. Do not bill Medicare directly for any services rendered to a Medicare Advantage PFFS member, except for hospice and Medicare approved clinical trials. Payment will be made directly by IBC.

Q. What reimbursement rates apply for PFFS patients?

A. You will be reimbursed the equivalent of the current Medicare payment amount for all covered services (i.e., the amount you would collect if the member was enrolled in Original Medicare.) Details are provided in the product Terms and Conditions.

Q. May I collect the member cost-sharing amount at the time of service?

A. Yes, providers may collect any applicable cost-sharing amount (i.e., copay, deductible). Details are provided in the product Terms and Conditions.

Q. Whom do I contact with questions regarding Medicare Advantage?

A. If you have any questions regarding the Medicare Advantage program or products, contact your Network Coordinator. ❖

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Medicare Advantage claims steps to follow

Members who enroll in Medicare Advantage products may seek services out of network. Coverage rules are likely to vary by product type and Medicare Advantage plan. When you furnish services to an enrollee in a Medicare Advantage plan, please note the following:

- 1. Ask for the member ID card.** Members have been asked not to show their standard Medicare card when receiving services; instead, members should provide their member ID card. The Blue Cross® and/or Blue Shield® logo will be visible on the ID card along with one of these logos that designate the type of health plan:

MEDICARE ADVANTAGE | PPO

MEDICARE ADVANTAGE | PFFS

MEDICARE ADVANTAGE | MSA

MEDICARE ADVANTAGE | HMO

MEDICARE ADVANTAGE | POS

- 2. Verify eligibility.** Do so by contacting [1-800-676-BLUE \(2583\)](tel:1-800-676-BLUE) and providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to Independence Blue Cross (IBC). You may also inquire electronically by using the 270/271 HIPAA eligibility transactions.

For Private Fee-for-Service (PFFS) plans, you should review the Terms and Conditions by using the Plan Finder tool located at www.ibx.com/providers/pffs/index.html.

- 3. Submit claims to IBC.** Do not bill Medicare directly for any services rendered to a Medicare Advantage member, except for hospice and Medicare approved clinical trials.

Payment information

Once you submit Medicare Advantage claims, IBC will send you the payment along with a Statement of Remittance (SOR). In general, you may collect the copayment amounts from the member at the time of

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Medicare Advantage claims steps to follow (continued from page 4)

service, but you may not otherwise charge or balance bill the member. The SOR will advise of any other member liabilities that you are able to collect.

PFFS payment information

In general, if you accept the Terms and Conditions and render services to a PFFS Medicare Advantage member, you are considered a deemed provider and will receive the Medicare payment rate for the covered services unless the PFFS plan has posted a higher payment rate in its Terms and Conditions. If you are a provider who accepts Medicare assignment and renders services to a Medicare Advantage member under a PFFS plan with whom you do not have a contract, you will be considered a non-

contracted provider and will be reimbursed the Medicare payment rate for all covered services as well. If it is an emergency or if you did not have an opportunity to know the patient was a PFFS member, you will be reimbursed the Medicare payment rate for all covered services as well. Providers should be certain they understand the applicable Medicare Advantage reimbursement rules. Please see the Terms and Conditions appropriate for the Medicare Advantage member for more details.

If you have any questions, please contact your Network Coordinator.

Note: Please make all claim status inquiries through 1-800-ASK-BLUE, prompt 2 for Provider Services. ❖

Blues move to automatic crossover for all Medicare claims: All claims will be automatically submitted to the secondary payer

All Blue Plans began to crossover Medicare claims for services covered under Medigap and Medicare Supplemental products on January 1, 2008. This process results in automatic claims submission of Medicare claims to the Blue secondary payer and reduces or eliminates the need for the provider's office or billing service to submit an additional claim to the secondary carrier. Additionally, with all Blue Plans participating in this process, Medicare claims will crossover in the same manner nationwide.

The information below explains the process in more detail.

How do I submit Medicare primary/Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification.

- Be certain to include the alpha prefix as part of the member ID number. The member's ID card will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage and is key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, verify if the claim has been automatically forwarded (crossed over) to the Blue Plan by the following differences:

- If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to resubmit that claim to Independence Blue Cross (IBC).
- If the remittance indicates that the claim was not crossed over, submit the claim to IBC with the Medicare remittance advice.
- For claim status inquiries, contact your Network Coordinator.

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Medicare-related claims: Present on Admission indicator for institutional billing

Effective October 1, 2007, the Centers for Medicare & Medicaid Services (CMS) required hospitals to use a Present on Admission (POA) indicator for every diagnosis for all patients discharged on or after that date. Using a POA indicator is a requirement of the Deficit Reduction Act of 2005. The act stipulates that the Secretary of Health and Human Services identify a limited number of high-cost and/or high-volume conditions that are reasonably preventable through application of evidence-based guidelines and pay at a lower rate when Medicare claims show these conditions as present only on discharge and not on admission. **Starting October 1, 2008**, claims may be assigned a lower-paying Diagnosis Related Group (DRG) when one of the secondary diagnosis codes identified by CMS is present on discharge but not present on admission.

Additional information about the POA indicator is included for your reference below.

What is the POA indicator?

The POA indicator is used to note a condition that is present at the time the order for inpatient admission occurs. It is noted by using one of the five values below that identify whether secondary diagnoses are present when the patient is admitted to a facility.

- Y = Yes
- N = No
- U = No information in the record
- W = Clinically undetermined
- 1 = Used on 4010A1 and 5010 versions of the 837 transaction to represent a space or a blank (diagnosis code is exempt from reporting POA)
- Blank = Designates on the UB-04 Claim Form Unreported/Not Used/Exempt from POA reporting

Is the POA indicator required on all Medicare claims?

The POA indicator is required on all Medicare primary claims, paper and electronic, and all Medicare Advantage claims, paper and electronic. It is not required on Medicare secondary claims.

What are the diagnosis codes for which CMS requires a POA indicator to be reported?

The diagnosis codes are located on the CMS website at www.cms.hhs.gov/HospitalAcqCond/.

Because a blank indicator is a valid value, will IBC reject my claim if the blank value is intentional?

A blank indicator is a valid value only on the UB-04 Claim Form. If the claim was received as an electronic submission, a blank value would represent an error. For a UB-04 Claim Form submission, a blank POA indicator is likely to not be an error when submitted by one of the exempt institutions (i.e., critical access hospitals, long-term care hospitals, cancer hospitals, and children's inpatient facilities). If the institution is non-exempt, clarification may be needed to determine if the provider left the POA indicator blank intentionally.

Whom should I contact with additional questions?

Information on the CMS POA indicator requirement is available at www.cms.hhs.gov/MLN MattersArticles/downloads/MM5499.pdf or by contacting your Network Coordinator. ❖

Helpful Q&As and quick tips for filing claims

As part of our ongoing efforts to better serve you, we are providing information to help make filing your Medicare claims easier. If you are a provider who accepts Medicare assignment and renders care to members from other Blue Plans, please note the following questions and answers (Q&As):

Q. What are Blue Cross and/or Blue Shield Medicare-related claims?

- A.** These are claims for coverage that are secondary/supplemental to Medicare and provided by a Blue Cross and/or Blue Shield plan. Examples include:
- Medigap (also called Medicare Supplemental, Medicare Complementary, and Medicare Extended)
 - Medicare Carve-out

Q. How do I identify a member with a Medicare-related policy?

- A.** Often, members will carry more than one ID card. A member's current ID card, when Medicare is the primary payer, should be a standard Medicare card without a Blue Cross and/or Blue Shield logo. Members may also present a separate ID card with a Blue Cross and/or Blue Shield logo for Medicare secondary coverage.

Q. Where do I submit Blue Cross and/or Blue Shield Medicare-related claims?

- A.** When Medicare is primary, submit claims to your Medicare intermediary and/or Medicare carrier. It is essential that you enter the correct Blue Plan name as the secondary carrier, which may be different from the local Blue Plan. Check the member's ID card for additional verification. The member ID card will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage and key to facilitating prompt payments.

After receipt of the explanation of payment, or Medicare Remittance Notice from Medicare, look to see if the claim has been automatically forwarded (crossed over). Note these differences in claims processing:

- If the remittance shows that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. There is no need to submit this claim to Independence Blue Cross (IBC).
- If the claim was not crossed over, submit the claim to IBC with the Medicare Remittance Notice.

Reminders for remittance advice

Do not submit Medicare-related claims to your local Blue Plan before receiving a Medicare Remittance Notice from the Medicare intermediary and/or Medicare carrier. Duplicate claims submissions can delay claims processing and create administrative inefficiencies for you and the insurance plan.

If you have any questions about claims filing, please contact your Network Coordinator. ❖



Additional resources

For inquiries on the status of:

- HMO facility BlueCard®
Claims, call IBC at
1-800-227-3119.
- PPO facility BlueCard Claims,
call IBC at 1-800-443-1776.

For questions about a member's BlueCard eligibility, call the BlueCard eligibility line at 1-800-676-BLUE (2583).

Inside IPP is a publication of the Provider Communications department. Suggestions are welcome.

CONTACT INFORMATION:

Rose Sutkowski
Managing Editor

Charleen Baselice
Production Coordinator

Provider Communications

Independence Blue Cross
1901 Market Street, 35th Floor
Philadelphia, PA 19103

provider_communications@ibx.com

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

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Blues move to automatic crossover for all Medicare claims: All claims will be automatically submitted to the secondary payer (continued from page 5)

When should I expect to receive payment?

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14 to 30 business days for you to receive payment from the Blue Plan.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to

your initial claim submission, don't automatically submit another claim. Rather, you should:

- review the automated resubmission cycle on your claim system;
- wait 30 days;
- check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Whom do I contact if I have questions?

If you have questions, please call your Network Coordinator. ❖

Medicare secondary billing

As you may know, the National Uniform Billing Committee (NUBC) has restricted the use of value codes A1, A2, A7, B1, B2, B7, C1, C2, and C7 to paper claims. These value codes are no longer available for use in the X12 837I (institutional) claim transaction.

For more detailed information regarding these updates, please visit www.ibx.com/providers/communications/bulletins/index.html. You may also contact your Network Coordinator with any questions about these value code updates for Medicare secondary billing. ❖