

# INSIDE **ipp**

AN INTER-PLAN PROGRAMS PUBLICATION



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## One-year anniversary of *Inside IPP*

This spring edition marks the one-year anniversary of the launch of *Inside IPP*, which was designed to answer your questions about Blue Cross and Blue Shield Inter-Plan Programs, including BlueCard® and Medicare Advantage. With this publication, we are also able to keep you informed of new or updated Inter-Plan Programs initiatives and provide up-to-date claims filing and instructional information.

Our goal is to improve your overall experience with BlueCard and Medicare Advantage processing and interaction with Independence Blue Cross and other independent Blue Cross and Blue Shield Plans.

Your input is of great value to us. We welcome and appreciate any feedback and comments you may have regarding *Inside IPP*. Is there a topic you would like us to address in a future edition? Please contact us at [InsideIPP@ibx.com](mailto:InsideIPP@ibx.com). ❖



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## *Inside IPP* provider survey coming soon

Your opinions are important to us as we plan future editions of *Inside IPP*. We are developing a survey to assess how *Inside IPP* meets your needs and how we can serve you better. The survey will only take a few minutes to complete and will be posted on [www.ibx.com/providers/blue\\_card](http://www.ibx.com/providers/blue_card).

Stay tuned for more information about this upcoming survey and what you can win for simply submitting your feedback. ❖

## New initiatives: Coordination of Benefits processing changes

As reported in our summer 2008 edition of *Inside IPP*, we are continually working to reduce the number of denials related to Coordination of Benefits (COB). The following is an overview of processing changes that were implemented for COB administration effective January 1, 2009.

- Providers may return a hardcopy of the online *Coordination of Benefits Questionnaire* for out-of-area members directly to the address printed on the front page of the *Coordination of Benefits Questionnaire*. We will then submit the COB data electronically to the Home Plan, which will have five business days to update the member's COB information. For additional information, please refer to the article *Submitting the BlueCard® Coordination of Benefits Questionnaire for out-of-area members* on page 3.
- All plans are required to proactively gather insurance information from their members. Plans may use any or all of the following approaches to gather COB data from members:
  - Gather COB information during the member's initial enrollment or during re-enrollment in an open-enrollment season.
  - Initiate welcome calls to new members to gather data.
- Place a removable sticker on member ID cards that requires members to activate their card before using it. Activation can be completed online or over the phone and will involve updating COB information.
- Members are required to update COB information during Customer Service calls as well as when they use self-service tools online.
- Blue Cross and Blue Shield Plans *may not* reject a claim to investigate for other insurance for fully insured business in the following situations:
  - if the patient is the subscriber;
  - for a dependent when the subscriber is primary under the birthday rule.
- Blue Cross and Blue Shield Plans *may* reject a claim to investigate for other insurance for fully insured business *only* if:
  - the member information indicates another primary carrier;
  - thirty days have elapsed from the receipt of the initial claim and at least two requests have been made with the member to update the information.

If you have any questions about these new COB initiatives, please contact your Network Coordinator. ❖

## Line, dollar, and unit expansion for claims

We are pleased to announce that effective November 2008, Blue Cross and Blue Shield Plans expanded their claims submission software and system interfaces to eliminate split-claim scenarios for high-dollar services. The number of lines and units of service that can be accepted on an out-of-area claim submission were also expanded.

This enhancement enables Blue Cross and Blue Shield Plans to accommodate 998 institutional claim lines, 50 professional claim lines, along with 9,999 units of service, and claim charges of \$99,999,999.99.

Below are a few advantages of the new software and system interfaces:

- eliminates the need to split high-dollar out-of-area claims;
- eliminates the need for providers to match multiple payments to a single claim;
- increases the institutional claim line limit from 23 lines to 998 lines on out-of-area claims;
- facilitates the accurate and timely payment of claims.

If you have any questions regarding this expansion, please contact your Network Coordinator. ❖

## Submitting the BlueCard® Coordination of Benefits Questionnaire for out-of-area members

In January 2009, we updated the BlueCard *Coordination of Benefits Questionnaire* for out-of-area members and streamlined the submission process. Out-of-area members are HMO, Traditional Hospitalization, and PPO members of other Blue Cross and Blue Shield plans who travel or live in the Independence Blue Cross (IBC) five-county service area\*. This BlueCard *Coordination of Benefits Questionnaire* should not be used for local IBC members or Federal Employees Program (FEP) members.

To avoid processing delays in claims payments, the provider or office staff must complete the first two fields on the questionnaire: the provider name and NPI. The provider or office staff should ask the out-of-area member to complete the remaining sections of the questionnaire before he or she leaves the office.

If the member chooses to complete the questionnaire outside of the office, he or she should be instructed to return the completed questionnaire to the provider's office. The provider or office staff should *immediately* forward the completed questionnaire to:

P.O. Box 69356  
Harrisburg, PA 17106-9356

This mailing address is prominently printed on the front page of the questionnaire.

Providers should not delay submission of the BlueCard *Coordination of Benefits Questionnaire* to coordinate with the claim submission. Claims should continue to be sent through your standard submission methods, which are separate from the submission of the BlueCard *Coordination of Benefits Questionnaire*.

The BlueCard *Coordination of Benefits Questionnaire* is available at [www.ibx.com/providers/blue\\_card/index.html](http://www.ibx.com/providers/blue_card/index.html) as well as in the *Reference Material and Reports* section on the NaviNet® web portal.

If you have any questions about these important instructions, please contact your Network Coordinator.

*Note:* Do *not* use the P.O. Box/ mailing address listed on the BlueCard *Coordination of Benefits Questionnaire* for any other correspondence. Only completed questionnaires for out-of-area members should be sent to this address. ❖

\*The IBC five-county service area includes Philadelphia, Bucks, Montgomery, Chester, and Delaware counties.

**Forward the completed questionnaire immediately to:**  
**P.O. Box 69356**  
**Harrisburg, PA 17106-9356**

**Do not use this P.O. Box for any other correspondence.**

**Blue Cross Blue Shield Association**  
An Association of Independent Blue Cross and Blue Shield Plans

**Coordination of Benefits Questionnaire:  
Out of Area Members**

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

Please mail this form to the following address:

**P.O. Box 69356  
Harrisburg, PA 17106-9356**

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name: \_\_\_\_\_ NPI (Give Tax ID if No NPI Number) \_\_\_\_\_  
 Last Name: \_\_\_\_\_ Policyholder First Name: \_\_\_\_\_  
 Group Number: \_\_\_\_\_ Member ID Number with Three Letter Prefix (Must Include Plan Alpha Prefix): \_\_\_\_\_

**Section A Other Insurance** *If this does not apply, check No and skip to Section B*

Are you or any other member of this Blue Cross Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross Blue Shield policy or Medicare?

No If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."  
 Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply:  Other Health Insurance  Other Dental Insurance  
 Group  Individual Policy  Student Policy  Medicare Supplemental

What type of policy is this? \_\_\_\_\_

Other Insurance Carrier's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dependent(s) listed on the other insurance: \_\_\_\_\_ Policyholder's Date of Birth: \_\_\_\_\_ ID Number: \_\_\_\_\_  
 Other Insurance Policyholder's Name: \_\_\_\_\_  
 Effective Date of Other Insurance: \_\_\_\_\_ If Cancelled, Cancellation Date: \_\_\_\_\_

Is the policy holder:  Actively working for the group  Inactive  
 Retired, retirement date: \_\_\_\_\_  On COBRA, which began: \_\_\_\_\_

Policyholder's Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Additional resources**

- For HMO and PPO BlueCard® facility claims, call Independence Blue Cross at 1-800-ASK-BLUE.
- For questions about a member's BlueCard eligibility, call the BlueCard Eligibility® line at 1-800-676-BLUE.

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

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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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## Reminder: Blues move to automatic crossover for all Medicare Claims — all claims will be automatically submitted to the secondary payer.

As you may already know, 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.

*Note:* Medicare Claims for Federal Employee Programs (FEP) do not automatically crossover at this time. ❖