

# INSIDE **ipp**

AN INTER-PLAN PROGRAMS PUBLICATION



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SUMMER 2008

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## Upcoming changes in COB administration

As we continue to streamline our claims processing and work to reduce the number of denials related to Coordination of Benefits (COB), **two changes will be made to COB administration, effective January 1, 2009.**

1. Out-of-area members will be able to return the online COB questionnaire directly to IBC. IBC will then submit the COB data electronically to the Home Plan, which will have five business days to update the member's COB information.

2. All plans will be required to gather insurance information from their members more proactively. 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 reenrollment in an open-enrollment season.

- Initiate welcome calls to new members to gather data.
- Place a removable sticker on member ID cards that require members to activate their card before using it. Activation can take place by phone or online and will involve updating COB information.
- Require members to update COB information during Customer Service calls as well as when members use self-service tools online.

If you have questions regarding these upcoming changes, please contact your Network Coordinator.

## 2008 BlueCard® Program satisfaction survey reminder

As we continue to evaluate our performance and improve claims processing, customer service, and electronic transactions, your feedback helps us set priorities and streamline operations.

We are still conducting provider satisfaction surveys to acquire timely feedback regarding your satisfaction with servicing out-of-area members. If your office is contacted, we encourage you to participate in the survey, as your opinions are important to us.

IBC's research vendor will ask to speak to office staff members with the most knowledge of BlueCard claims filing and/or billing. Please inform the appropriate staff members to anticipate being contacted by our vendor.

If you need information about the BlueCard Program or have suggestions for improvement, there are three ways to contact us:

- Talk to your Network Coordinator.
- Visit us online at [www.ibx.com/providers](http://www.ibx.com/providers).
- Contact Provider Services.
  - HMO: 1-800-227-3119
  - PPO: 1-800-443-1776

As always, we appreciate your feedback.

### Did you know?

There are three ways that you can validate another Blue Plan member's eligibility and benefits.

- 1. Initiate a BlueExchange® inquiry using NaviNet®.** Go to *BlueExchange Eligibility and Benefits* and enter all required fields for the search. Real-time responses are available for out-of-area members Monday through Saturday from 5 a.m. to 10 p.m. EST and Sunday from 9 a.m. to 9 p.m.
- 2. Submit a HIPAA 270 transaction electronically to IBC.** Real-time responses are available Monday through Saturday from 7 a.m. to 1 a.m. EST.
- 3. Call BlueCard® Eligibility.** You can reach BlueCard Eligibility at 1-800-876-BLUE (2583), where phone operators are available to assist you in English or Spanish. Blue Plans are located throughout the country and may operate on a different schedule than IBC, so you may be transferred to a voice response system linked to customer enrollment and benefits. Please note that the BlueCard eligibility line is intended for benefits and precertification/referral authorization inquiries only.

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## BlueCard® FAQs now online

To assist you and your staff in further understanding how the BlueCard Program works, we have compiled answers to frequently asked questions (FAQs) regarding the program. This collection of information is divided into the following categories:

- General
- Eligibility and benefits
- Utilization management
- Coding and billing
- Claims processing

A complete set of FAQs is available online at [www.ibx.com/providers/blue\\_card/index.html](http://www.ibx.com/providers/blue_card/index.html). Below are some examples of FAQs, listed by category.

### General

#### **How do I identify a BlueCard member?**

Most BlueCard PPO members have a “PPO in a suitcase” logo, while Traditional Indemnity, POS, HMO, and Medicare Complementary BlueCard members have a “blank suitcase” logo on the front of their ID card. However, some ID cards may not have a suitcase logo; therefore, call BlueCard Eligibility to verify whether the BlueCard Program applies.

#### **What if the member’s ID number does not contain an alpha prefix?**

For ID cards with no alpha prefix, verify that you have the member’s current ID card. Look for claim-filing instructions or a telephone number on the ID card. Do not send the claim to IBC unless indicated on the ID card.

### Eligibility and benefits

#### **May an account dictate the type and/or specialty of providers eligible to perform certain services?**

Yes. An account may exclude specific provider types under the benefit terms of a member’s contract. When a claim is denied for such an excluded provider type, the discount is lost and the member is held responsible up to charges since the services are not a covered benefit.

#### **Why is it more common to see benefits restrictions on provider type and provider specialty for behavioral health benefits?**

It is more common to see explicit benefits restrictions that dictate the provider type and specialty that are eligible to render services for behavioral health benefits in conformity with industry standards.

### Utilization management

#### **Am I required to cooperate with the member’s Blue Plan preauthorization and precertification programs?**

While an out-of-area BlueCard member is responsible for obtaining precertification or prior authorization from his or her Home Plan, you may choose to handle this obligation on the member’s behalf.

#### **How should the claim be handled if the Home Plan doesn’t allow for a service under its medical policy but IBC does under its provider contract?**

If IBC allows for the service under its provider’s contract, IBC will apply the IBC price and send the claim to the Home Plan. If the member doesn’t have coverage for the specific service or doesn’t meet the medical necessity criteria for the service, the Home Plan will deny the claim and the claim will be the member’s liability. Only the reimbursement rate is applied by the Host Plan; benefits and medical policy are applied by the Home Plan.

### Coding and billing

#### **May a Home Plan and/or account dictate the type of claim form upon which services must be billed?**

No. Provider billing practices are IBC’s responsibility that Home Plans must honor. Home Plans may not apply their local billing practices on claims that were rendered in IBC’s service area.

#### **May a Home Plan and/or account dictate how claims are billed?**

Provider billing practices are a Host Plan responsibility that Home Plans must honor. Home Plans may not

### 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.

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### BlueCard® FAQs now online (continued)

apply their local billing practices on claims that were rendered in IBC's service area.

*Examples:*

- A Home Plan and/or account may not require that anesthesia, when rendered by a certified registered nurse anesthetist, be billed by an anesthesiologist.
- A Home Plan may not dictate how mother/newborn claims are billed. IBC's billing rules and reimbursement policies dictate if services are billed together or separately.

*Exception:* If a member's benefits agreement specifically outlines the manner in which certain services must be billed and/or paid to be considered a covered service, then the Home Plan may deny services and ask IBC to resubmit the claims in a manner that is consistent with the member's benefits. However, IBC is under no obligation to do so and may not be able to accommodate the request if it conflicts with our contract with the provider.

In these situations, a Home Plan may deny the services as noncovered and the member may be held responsible up to charges.

### Claims processing

#### What happens when documentation for medical review is required for a BlueCard claim?

If medical documentation is required by the member's Home Plan, IBC will request the documentation from you. The member's Home Plan is responsible for benefit coverage and medical necessity determinations.

#### Which Plan is responsible for pricing the claim?

Host Plans are responsible for pricing claims. Home Plans must accept Host Plan's contracted pricing agreements. If the Home Plan denies a service as noncovered or receives a claim at the billed charge (if there is no Host contracted rate), the Home Plan may apply its own pricing, but the member may be liable up to charges.

## In the spotlight: DVHC

IBC Provider Network Services, Provider Contracting, and Inter-Plan Programs (IPP) staff recently hosted a meeting to review BlueCard® processes and identify ways to improve program interactions. In attendance was Pam Clarke, vice president, Managed Care of Delaware Valley Healthcare Council (DVHC) of HAP, along with member representation from Community Health Systems, Crozer-Chester Medical Center, Fox Chase Cancer Center, and Jefferson Health Systems.

The DVHC participating member facilities provided IBC's IPP staff with complex scenarios related to topics like medical records, split claims, and noncovered services so case studies could be developed for each scenario. Using these case studies as guides, IBC and DVHC will be able to identify effective ways to handle complex BlueCard situations.

Updates on further developments from the DVHC/IBC collaboration will be featured in future issues of *Inside IPP*.