

INSIDE **ipp**

AN INTER-PLAN PROGRAMS PUBLICATION



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Inside IPP survey findings and suggestions

We want to thank those who took the time to complete our *Inside IPP* web survey. The purpose of the survey was to assess how we can serve you better and more effectively meet your BlueCard® Program needs.

We have compiled the feedback we received, and we would like to share some highlights from our analysis of the completed responses.

Background

The *Inside IPP* web survey was conducted during June and July through the IBC provider website. The web survey was completed by 106 office staff. Of those who completed the survey, 44 percent of the respondents were employed at hospitals. The other 56 percent represented physician offices, ancillary facilities, and billing companies.

Findings

The majority of respondents have read an edition of *Inside IPP* in the previous year. Reader responses were positive based on these figures:

- Eighty-six percent of readers were satisfied with the publication. Overall, no readers were dissatisfied.
- *Inside IPP* improved the BlueCard experience for nearly two-thirds of office staff who read the publication, illustrating the positive impact of the publication.
- The majority of readers found *Inside IPP* to be a convenient source of new information. More than 80 percent of readers agreed that the information provided was useful or new.

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Aged claims affect plans and their partner plans

A Blue Cross and Blue Shield Association (BCBSA) and Blue Cross and Blue Shield Plan review of Inter-Plan claims shows that 98.3 percent of claims are finalized within 60 days, with the remaining 1.7 percent of claims aging 61+ days until finalized. In addition, the existing quarterly CEO reporting for Inter-Plan performance did not reflect system-wide aged inventory to allow plans to understand where they rank in terms of inventory management compared to their peers.

Therefore, in order to improve Inter-Plan claims timeliness, the BCBSA and the Plans have established a new Aged Claims CEO Reporting requirement to address aged claims. The report includes all open inventory, which is defined as all claims that have not been finalized and are aged more than 30 days. A plan may not carve out any claims from their open inventory report. Claims that are delayed (e.g., due to a Coordination of Benefits investigation, medical record requests, etc.) must be included in a plan's reporting.

The intent of the report is to highlight plan impacts on its partner plans and its partner's provider community. Plans recognize that CEO reporting is an effective method for highlighting aged claims and open inventory and is seen as a means to bring additional attention to aged claims.

The new aged claims reporting policy became effective April 1, 2009. Plans began submitting monthly reports to their CEOs, with a copy to the BCBSA in May 2009. Monthly reports are due to the BCBSA by the 10th of each month, reporting aged claims data for the previous month.

The BCBSA will use this data to provide system-wide aged claims data to plan CEOs in the third quarter. We will provide updates in subsequent issues of *Inside IPP* on the impact of the Aged Claims CEO Reporting process on Inter-Plan claims timeliness. ❖

Inside IPP web survey key findings and suggestions (continued)

- Many readers commented that *Inside IPP* is helpful, informative, timely, and a good reference to share with colleagues. Readers also commented on the ease of viewing and reading the publication.
- Roughly 20 percent of respondents have not read *Inside IPP*. The most common reasons provided were time constraints or being unaware of the publication.



Suggestions on how to improve *Inside IPP*

Respondents provided insight on how we can improve their BlueCard experience. Suggestions include:

- providing specific information about products or procedures; often, readers requested information that was specific to their provider or facility type;
- communicating pertinent information, such as policy changes.

We will continue to analyze the survey responses to provide you with useful information. In a future edition of *Inside IPP*, we will detail how we plan to enhance our quarterly publication.

Congratulations to our winners

The winners of the four \$25 Visa® gift cards were selected from a random drawing. Gift cards were mailed to the winners in August. Again, thank you for your valuable feedback and suggestions. ❖



BlueSquared® facilitates Inter-Plan business processes and messaging services for Home and Host plans

BlueSquared (Blue²®) is the Blue Cross and Blue Shield Association's web-based application suite that facilitates Inter-Plan business processes in real-time. It provides common plan services and Inter-Plan messaging services.

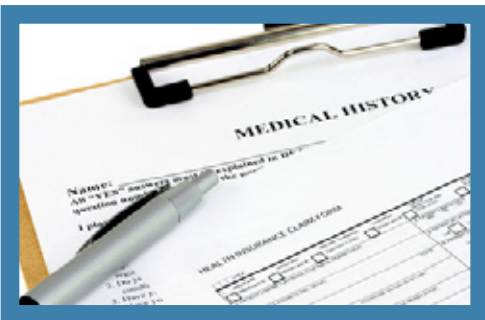
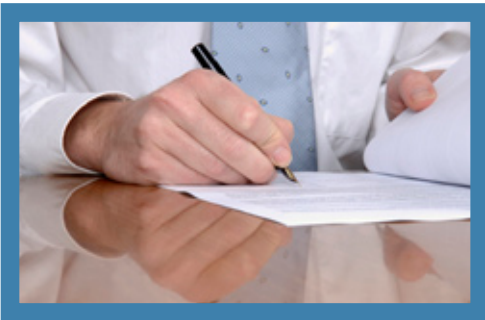
Unlike BlueExchange®, which is used for communication between the provider and the Blue Cross and Blue Shield Plans, Blue² is an application that is specifically designed to be used by the Home and Host Plans to exchange information related to Inter-Plan claims. The business goal of this web-based application is to improve provider satisfaction and facilitate operational excellence.

Blue² is being enhanced in stages and new capabilities are being added each year. Currently, Blue² enables plans to:

- exchange informational messages and general inquiries;
- exchange case-specific rate negotiation;
- exchange provider network-related questions and messages;
- track misrouted claims;
- obtain claims status inquiries for Inter-Plan claims;
- manage claims inventory;
- view claim formats;
- request medical records;
- send electronic attachments, including:
 - claim misroutes;
 - medical records;
 - Coordination of Benefits questionnaires;
 - appeals.

Business processes that can be handled via Blue² will eventually include claims submissions, claims dispositions and adjustments, and claims settlements (dispositions and reconciliations).

The vision for Blue² is that this web-based application will be continually enhanced and will serve as a flexible platform for services to support current and future Inter-Plan business requirements. ❖



NDC submission changes for institutional providers

For institutional providers: Effective September 21, 2009, we now require all claims for outpatient services containing the following administrative and pharmacy revenue codes and an **unlisted and/or nonspecific** (CPT® or HCPCS) drug code(s) to also include a valid National Drug Code (NDC) when submitted: 250 – 259, 262, 263, 331, 332, 335, 343, 344, and 631 – 637. By requesting this detailed drug billing information, we can provide greater transparency for our members and providers.

NDC billing information

Please submit the NDC using the 5-4-2 format when billing with hyphens (e.g., 12345-1234-12). NDC numbers without hyphens (e.g., 12345678911) will also be accepted. Please do not include spaces, decimals, or other characters in the 11-digit string, or the claim will be returned to you for correction prior to processing.

Certain claims for unlisted and nonspecific drug codes that are not accompanied by an NDC in the correct format and location will not be processed and will be returned to you for correction and resubmission. Please note that the NDC requirement is applicable to the claim processing date and not the date of service.

The complete list of unlisted and non-specific codes that require the submission of an NDC is included below.

Unlisted codes that require submission of an NDC*

Code	Description
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
A4641	Radiopharmaceutical, diagnostic, not otherwise classified
A9150	Nonprescription drug
A9152	Single vitamin/mineral/trace element, oral, per dose, not otherwise specified
A9579	Injection, gadolinium based magnetic resonance contrast agent, not otherwise specified, per ml
A9698	Nonradioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9700	Supply of injectable contrast material for use in echocardiography, per study
C2698	Brachytherapy source, stranded, not otherwise specified, per source
C2699	Brachytherapy source, nonstranded, not otherwise specified, per source
C9399	Unclassified drugs or biologicals
J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
J3490	Unclassified drugs
J3530	Nasal vaccine inhalation

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NDC submission changes for institutional providers (continued)

Code	Description
J3535	Drug administered through a metered dose inhaler
J3590	Unclassified biologics
J7199	Hemophilia clotting factor, not otherwise classified
J7599	Immunosuppressive drug, NOC
J7699	NOC drugs, inhalation solution administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal/suppository, not otherwise specified
J8499	Prescription drug, oral, nonchemotherapeutic, NOS
J8597	Antiemetic drug, oral, not otherwise specified
J8999	Prescription drug, oral, nonchemotherapeutic, NOS
J9999	NOC, antineoplastic drug
Q3001	Radioelements for brachytherapy, any type, each
Q4082	Drug or biological, not otherwise classified, Part B drug competitive acquisition program (CAP)
Q4096	Injection, von Willebrand factor complex human, ristocetin cofactor (not otherwise specified), per I.U. VWF:RCO
S5000	Prescription drug, generic
S5001	Prescription drug, brand name

**These codes are subject to change pending routine updates.*

Listing these codes on the table does not imply that a separate payment will be made for the code but that all current and future coding edits apply, and that these codes should be reported only when there is not a more specific code.

Please submit an NDC in the following fields:

Electronic institutional claims: 837I Loop 2410/Data Element LIN02 = N4 qualifier and Data Element LIN03 = NDC

- Example: LIN**N4*00093723106-

Paper institutional claims: box 43 (revenue code description)

Report the N4 qualifier in the first two positions left-justified followed by the 11-digit NDC with no spaces in between.

- Example: N400093723106 ❖

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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New federal Mental Health Parity and Addiction Equity Act effective October 3, 2009

The Federal Mental Health Parity and Addiction Equity Act was signed into law on October 3, 2008. The law becomes effective October 3, 2009, and applies to groups when either the group contract renews or upon issuance of a contract to new groups. A summary of the law is outlined below to help prepare you for questions that your BlueCard patients may have about the law.

The law applies to members who are covered by group health plans with 51 or more employees, and it requires that mental health and substance abuse benefits, if they are provided, be in parity with (or equal to) medical and surgical benefits.

As a result of the new law, members may experience some benefits changes, including the removal of limits on inpatient days and outpatient visits as well as differences in cost-sharing (e.g., deductibles, copayments, coinsurance, and out-of-pocket expenses) for mental health and substance abuse services. Please note that a plan's current medical management (e.g., precertification) will not be affected by the law.

The law applies to all commercial managed care (HMO, POS, Direct POS, and PPO) and Traditional (Blue Cross Hospitalization, Blue Shield Medical Surgical, Major Medical, and Comprehensive Major Medical/CompSelect®) plans.

If your BlueCard patients have questions about the Mental Health Parity and Addiction Equity Act, they should contact Customer Service at the phone number located on their ID cards. ❖

