

# INSIDE **ipp**

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## Quick tips to assist you with FEP claims inquiries

IBC understands the importance of excellent customer service, and we are focusing on innovative ways to continually deliver exceptional service to our providers. IBC's Federal Employee Program (FEP) service area developed quick tips to assist you with claims inquiries. These quick tips outline the essential information we need to ensure efficient, timely, and accurate responses to your inquiries. By having specific information available, the service representative will retrieve the appropriate data to respond to your inquiries.

When you call [215-241-4400](tel:215-241-4400), please have the following information available:

- **National Provider Identifier** – This is a distinct ten-digit number assigned to in-network participating providers that identifies you, the provider. This number is located in box number 56 of the UB-04 claim form.
- **Date of service, charge amount, and admit date** – Having the date of service, charge amount, and admit date available will assist the service representative when searching our claims data.
- **Electronic vs. paper billing** – Knowing whether the claim was submitted electronically or on paper will help the service representative locate your claim in our database.
- **Primary vs. secondary billing** – If you are calling in reference to a secondary payment, please notify the service representative at the beginning of the call so he or she can locate claim information accordingly.

For more information about the UB-04 claim form, please visit [www.ibx.com/pdfs/providers/npi/ub04\\_form.pdf](http://www.ibx.com/pdfs/providers/npi/ub04_form.pdf).

*Note:* IBC handles only facility claims for FEP members. If you are a professional provider and have questions about your claims submissions, please contact your Highmark Blue Shield provider representative at 1-866-975-7290 or 215-564-2131. ❖

## Never Events: Stipulations, specifications, and differences between BlueCard® (Inter-Plan) and FEP claims

Never Events are considered adverse events or errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. Recently, Never Events have become an issue that requires attention by health insurance companies.

In 2008, the Centers for Medicare & Medicaid Services (CMS) eliminated additional payments to hospitals for certain preventable conditions acquired during the hospital stay, as well as issued a National Coverage Determination that it would not cover *wrong surgeries* (e.g., wrong patient, wrong body part, or wrong procedure). Additionally, national competitors and several states implemented similar Never Events policies, while Blue National Accounts have requested consistency in how the Blue Cross® and Blue Shield® Plans manage Never Events.

To meet market demand as well as to demonstrate IBC's commitment to quality health care, policy requirements were passed in March 2009 to create a consistent approach to address Never Events. The requirements became effective January 1, 2010, and apply to Inter-Plan Programs (IPP), IPP Medicare Advantage Programs, and the FEP.

### **The FEP Never Events policy stipulates that Plans:**

- require all hospitals that are contracted with local Blue Cross and Blue Shield Plans to populate the *present on admission* field indicator on all inpatient hospital claims for all Never Events, as applicable;
- do not reimburse hospitals that are contracted with local Blue Cross and Blue Shield Plans for inpatient services related to Never Events from FEP funds;
- require all hospitals that are contracted with local Blue Cross and Blue Shield Plans to hold members and the FEP harmless for any inpatient services related to Never Events.

### **The differences and specifications regarding the implementation of the FEP and IPP Never Events policy are as follows:**

- The FEP Never Events policy covers all participating provider and member inpatient hospital claims; the IPP policy is limited to inpatient claims from *acute care* facilities.
- The FEP Never Events policy requires IBC to work with the facility to split the claim to remove the charges related to Never Events before processing the approved charges; the IPP policy does *not* require IBC to split the claim.

For more information about the operational processes related to Never Events, please contact your Network Coordinator. ❖

## Claims submissions for FEP members with Medicare and IBC coverage

Through the Medicare Crossover process, we now accept FEP facility claims electronically for members with Medicare and IBC coverage from Group Health Incorporated (GHI) and CMS. Previously, we accepted only Security 65® Supplemental claims through the Medicare Crossover process.

GHI and CMS process and adjudicate the primary benefits for FEP facility claims for members with FEP Medicare and IBC coverage and “cross over” these claims to us by an electronic file submission for secondary processing and adjudication. We process and adjudicate the claims according to the IBC benefits plan (secondary coverage).

We implemented this change to improve the timeliness and accuracy of claims processing. Please do not send FEP Medicare secondary claims (IBC coverage) directly to us through paper or electronic submissions.

If you have any questions about this process, please contact your Network Coordinator. ❖

**Additional resources**

- For HMO and PPO BlueCard® facility claims, call IBC at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE).
- For questions about a member's BlueCard eligibility, call the BlueCard Eligibility® line at [1-800-676-BLUE](tel:1-800-676-BLUE).

*Inside IPP* is a publication of Independence Blue Cross and its affiliates (IBC). 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**  
[InsideIPP@ibx.com](mailto:InsideIPP@ibx.com)

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The Blue Cross and Blue Shield words and symbols, BlueCard, and BlueCard Eligibility are registered marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

## The Service Benefit Plan and its options

The Blue Cross and Blue Shield Service Benefit Plan, also known as the FEP, has been part of the Federal Employees Health Benefits Program (FEHBP) since its inception in 1960. The FEP is the largest privately underwritten health insurance program in the world.

Blue Cross and Blue Shield Plans, as a whole, insure roughly 4.6 million federal employees, retirees, and their families out of the nearly 8 million people who receive their benefits through the FEHBP. Approximately 60 percent of all federal employees and retirees who receive their health care benefits through the government's FEHBP are members of IBC's FEP Service Benefit Plan, as opposed to one of the Blue Cross and Blue Shield Plans' competitors (e.g., Aetna, Cigna).

The Blue Cross and Blue Shield Association (BCBSA) negotiates annually with the U.S. Office of Personnel Management to determine the benefits and premiums for the FEP program. IBC is one of the 39 local member plans of the BCBSA. IBC's core responsibilities include processing claims and providing customer service to providers and members. The FEP offers its members two benefits options: Standard or Basic.

The same services are covered under both the Standard and Basic options, but at different payment levels. The distinguishing differences between the two options are as follows:

- **Standard** – This option is structured like a PPO product that allows the member freedom and flexibility to visit a provider of his or her choice, either in or out of the local plans' network. This benefit option includes higher premiums and out-of-pocket expenses, such as copayments, coinsurances, and deductibles.
- **Basic** – This option is structured like a PPO product that allows the member freedom and flexibility to visit a provider of his or her choice within the local plans' network. While the out-of-pocket expense is lower, members are responsible for copayments only.

Please visit [www.fepblue.org](http://www.fepblue.org) to locate detailed resources regarding the benefits offered under the FEHBP. ❖

