

INSIDE **ipp**

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Reminder about precertification/ preauthorization for services

Please remind your BlueCard® patients that they are responsible for obtaining precertification/preauthorization for inpatient and outpatient services as required under their Home Blue Plan.

In non-diagnosis-related group/case rate situations when the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved prior to or by the last day of the original approved days. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

Providers may also contact the member's Home Blue Plan for approval on his or her behalf by:

- calling the BlueCard Eligibility® line at **1-800-676-BLUE (2583)** and asking to be transferred to the utilization review area;
- submitting an electronic HIPAA 278 transaction (referral/ authorization) to Independence Blue Cross.

The member's Home Blue Plan may contact providers directly for clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member. ❖

Provider Satisfaction Survey

Your office may be contacted to participate in our provider satisfaction survey to assess your satisfaction with servicing out-of-area members. Your opinions are important to us, and we encourage you to participate in the survey. Your feedback helps us to evaluate our performance and improve claims processing, customer service, and electronic transaction submittals.

Please inform the office staff member who handles BlueCard® claims filing and/or billing that your office may receive a letter from our research vendor in early January 2009. The letter will invite the staff member who is most knowledgeable of claims processing to participate in an online survey. The vendor will then conduct a follow-up phone call between January 7 and February 4, 2009, to offices who have not responded to the online survey asking the designated staff person if he or she would prefer a telephone survey. ❖

Consumer directed health care and health care debit cards

Consumer directed health care (CDHC) is a term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. Health plans that offer CDHC options provide the member with additional information to make informed and appropriate health care decisions through the use of member support tools, provider and network information, and financial incentives. Members who have CDHC plans often carry health care debit cards that allow them to pay out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), or Flexible Spending Account (FSA). All three are types of tax-favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some CDHC cards are stand-alone debit cards that cover eligible out-of-pocket costs, while others also serve as the member's health plan ID card. These debit cards can help providers to simplify their administration process as well as:

- reduce bad debt;
- reduce paperwork for billing statements;
- minimize bookkeeping and patient-account functions for handling cash and checks.

The combined debit/member ID CDHC card will have the nationally recognized Blue logos along with the logo from a major credit card company, such as MasterCard® or Visa®.

Both types of CDHC cards include a magnetic strip, which allows providers to swipe the card at the point of service and collect the member's cost-sharing amount (i.e., copayment). With health debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card through any debit card swipe terminal. The funds are automatically deducted from the member's designated HRA, HSA, or FSA.

The combination of a health insurance ID card with a source of payment is an added convenience to both members and providers. Members may use their cards to pay outstanding balances on billing statements and request payments to be processed by telephone. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

Sample stand-alone health care debit card



Sample combined health care debit card and member ID card



Please consider the following tips when handling CDHC cards:

- Carefully determine the member's financial responsibility before processing payment. Providers can access the member's accumulated deductible by contacting the BlueCard Eligibility® line at 1-800-676-BLUE (2583).
- Ask members for their current member ID card and regularly obtain new photocopies (front and back). Having the current card will enable providers to submit claims with the appropriate member information (including alpha prefix), avoiding unnecessary claims payment delays. ❖

Glossary of BlueCard® Program terms

Please familiarize yourself with the important BlueCard-related terms listed below. These terms are frequently referenced in our quarterly *Inside IPP* publication.

Alpha prefix

These are the three characters that precede the subscriber ID number on Blue Plan ID cards. The alpha prefix identifies the member's Blue Plan or national account and is required for routing claims.

BlueCard Access®

Providers and patients may use this toll-free number, 1-800-810-BLUE (2583), to locate health care providers in another Blue Plan's service area. This number is useful when providers need to refer the patient to a physician or health care facility in another location.

BlueCard Eligibility®

This toll-free number, 1-800-676-BLUE (2583), allows providers to verify membership and coverage information, as well as obtain precertification for patients from other Blue Plans.

BlueCard® PPO

This is a national program that offers members who are traveling or living outside of their Blue Plan's service area the PPO level of benefits when they receive services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard® PPO member

This member carries an ID card with the "PPO in a suitcase" logo. Only members with this identifier may access the benefits of BlueCard PPO.

BlueCard Worldwide®

This program allows Blue members who are traveling or living abroad to receive access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from health care providers worldwide. The program also allows members of foreign Blue Cross® and/or Blue Shield® Plans to use domestic Blue provider networks.
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Consumer directed health care/health plans

Consumer directed health care (CDHC) is a broad term that refers to a movement in the health care industry to empower members, reduce employer costs, and change consumer health care purchasing behavior. CDHC provides members with additional information to make informed and appropriate health care decisions through the use of member support tools, provider and network information, and financial incentives.

Coinsurance

This provision in a member's coverage limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional out-of-pocket cost.

Coordination of benefits

Coordination of benefits (COB) allows members to receive up to 100 percent of the total allowable expenses for covered services, while ensuring that he or she does not collect more than the actual cost of the covered health expenses. When a member is covered by more than one health care plan, one plan is determined to be primary, and its benefits are applied to the claim first. Reimbursement of the remaining balance is considered through the secondary and/or tertiary policy, subject to benefit provisions.

Copayment

A charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount that a member incurs before the insurer will make any benefit payments.

Medicare Advantage

A plan offered by a private company that contracts with Medicare to provide Medicare Part A (Hospital) and Part B (Medical) benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service plan, or a Medicare Savings Account plan and generally offers Medicare Part D (prescription drug coverage).

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 (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

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Glossary of BlueCard® Program terms

(continued)

Medicare crossover

The crossover program was established to allow Medicare to transfer Medicare Summary Notice information directly to a payer with Medicare's supplemental insurance company.

Medigap

Medigap is a Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Note: A Medicare Advantage plan is not a Medigap policy.

National account

This employer group contains employee and/or retiree locations in more than one Blue Plan's service area.

Other Party Liability

An other party liability (OPL) is a cost-containment program designed to coordinate claim payments so that Blue Plans meet their responsibilities efficiently, without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPLs include coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

Plan

This term refers to any Blue Plan. ❖

Quick tips on filing claims

A valuable feature of the BlueCard Program is that providers can file all claims for members from other Blue Cross® and/or Blue Shield® Plans with their local plan.

Please keep the following tips in mind when filing claims:

- Make a copy of the front and back of the member's ID card.
- Look for the 3-character alpha prefix that precedes the member's ID number on the ID card.
- Call the BlueCard Eligibility® line at 1-800-676-BLUE (2583) to verify the patient's membership and coverage, or submit an electronic HIPAA 270 transaction (eligibility) to the local plan.
- Submit the claim to Independence Blue Cross. Always include the patient's complete ID number, which includes the 3-character alpha prefix.
- Call your Network Coordinator for claims inquiries. ❖