

INSIDE **ipp**

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Precertification/preauthorization required for diagnostic imaging services

American Imaging Management, Inc. (AIM), an independent company, performs precertification for outpatient, nonemergent diagnostic imaging services for our managed care members.

Ordering physicians are required to obtain precertification for the following outpatient nonemergent diagnostic services:

- CT/CTA scans
- PET scans
- PET/CT fusions
- Nuclear cardiology services
- MRIs
- MRAs

Reviews for the above procedures will be performed by AIM, as IBC's designee, according to medical necessity criteria. The ordering physician — primary care or specialist — is required to obtain precertification for the outpatient nonemergent diagnostic services listed above through the NaviNet® web portal, phone, or fax. Failure to precertify procedures may result in an administrative denial regardless of medical necessity. Precertification can be obtained by calling **1-800-ASK-BLUE**.

Please visit www.americanimaging.net for guidelines on AIM's imaging procedures.

An ordering physician outside of the IBC service area should secure a preauthorization from the member's Home Plan. A rendering facility/provider (performing the actual imaging study) should also ensure that an authorization has been obtained before performing the services.

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




Eligibility, benefits verification, and claims processing tips

Many of your patients may receive new ID cards for the 2010 benefits year. To help ensure prompt and accurate claims processing, please make sure you have a copy of the patient's current ID card on file for claims submissions.

The following tips may be helpful when providing services to out-of-area members:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, verification will ensure that you have the most up-to-date information in your patient's file.
- Make copies of the front and back of the member's ID card and provide this key information to your billing staff.
- Blue Plan member ID cards include a 3-digit alpha prefix in the first three positions of the member's ID number. This number identifies the member's Blue Plan and is critical for eligibility, benefits verification, and claims processing. The alpha prefix may be followed by up to fourteen additional characters, which may be a combination of letters and numbers.

Examples of ID card numbers:

ABC1234567	ABC1234H567	ABC1234H5678901234
		
Alpha prefix	Alpha prefix	Alpha prefix

- Remember to file the claim with IBC and to report member ID numbers exactly as shown on the ID card. Do not add, omit, or alter any characters from the member ID number.
- To check eligibility, benefits, and precertification requirements, send an electronic eligibility inquiry to IBC or call [1-800-676-BLUE](tel:1-800-676-BLUE) and provide the member's 3-digit alpha prefix.

If you have any questions, please contact Customer Service at [1-800-ASK-BLUE](tel:1-800-ASK-BLUE). ❖

Blue Distinction® designation for delivering quality health care

Blue Distinction is a designation awarded by the Blue Cross and Blue Shield Association (BCBSA) to medical facilities that have demonstrated expertise in delivering quality health care. The designation is based on rigorous, evidence-based selection criteria established in collaboration with expert physicians and medical organizations. The goal is to raise the quality of care delivered nationwide and to help consumers find specialty care in facilities proven to have delivered better overall outcomes.

The Blue Distinction Centers for Specialty Care® identify quality providers of bariatric surgery, cardiac care, complex and rare cancers, spine surgery, hip and knee replacements, and transplants. For each specialty area, the BCBSA collaborates with leading medical organizations to thoroughly review nationally established measures and includes input from expert physicians. Designation as a Blue Distinction Center for Specialty Care means the selected facilities' overall experience and aggregate data met objective criteria established in collaboration with recommendations from expert clinicians and leading professional organizations.

All facilities must regularly reapply for the designation (typically every 18 to 36 months) to help maintain consistent quality among facilities that have earned the Blue Distinction designation. These re-evaluation cycles provide an opportunity for the BCBSA to work with expert physicians and medical organizations to determine whether any of our quality thresholds should be raised based on current clinical practice and to foster ongoing opportunities for improving the overall quality of care.

For more information or to apply for the Blue Distinction designation for your medical facility, please visit www.bcbs.com/innovations/bluedistinction/blue-distinction-for-providers. ❖

Factors determining pre-existing medical condition exclusions

A pre-existing condition is a medical condition that existed before a patient obtained health insurance coverage. Under the Health Insurance Portability and Accountability Act, a group health plan is allowed to look back no more than six months for a condition that was present before the start of coverage in a group health plan. A pre-existing condition exclusion can be imposed only if medical advice, diagnosis, care, or treatment was recommended or received during the six months prior to the patient's enrollment date in the group health plan.

For example, the patient may have had heart disease for many years. If the patient did not have medical advice, diagnosis, care, or treatment — either recommended or received — in the six months before he or she was enrolled in the group health plan, the prior condition cannot be subject to a pre-existing condition exclusion. If the patient received medical advice, diagnosis, care, or treatment within the previous six months, the group health plan may impose a pre-existing condition exclusion for that condition (in this example, heart disease).

In most cases, there is a 12-month waiting period for pre-existing medical condition coverage. That means that a patient's coverage may not provide coverage for that specific pre-existing medical condition for 12 months. The pre-existing condition exclusion is normally reduced for each month that a patient had qualifying health insurance coverage without a break in coverage. Patients normally receive credit toward their pre-existing waiting period for up to 12 months for the time they were enrolled with another carrier.

When a pre-existing condition is suspected by the patient's Home Plan based on a diagnosis code on the claim, that plan sends a request through BlueSquared® (Blue²) to the Host Plan outlining the information needed from the provider to continue claims processing. Typically, the Home Plan requires the diagnosis code, treatment date, and the request of onset. The Host Plan receives and reviews requests sent and then contacts the hospital's billing department to obtain the requested information. The information obtained from the provider is transmitted back to the Home Plan through Blue², and the Home Plan proceeds with the claims adjudication based on the information received.

If a Home Plan requires information from the attending physician or the patient's primary care physician to finalize a claim, IBC will direct the Home Plan to contact Highmark Blue Shield to obtain the required information. Highmark Blue Shield is responsible for all interactions with professional providers for Host claims.

Note: This information does not apply to Medicare Advantage or individual/non-group health plans. For individual/non-group health plans, the waiting period begins on the day the application is submitted. The look-back period may extend up to five years for a condition that was present before the day the application was submitted. ❖



Requesting medical records provides resolution in BlueCard® claims issues

A medical record documents a member's medical treatment, past and current health status, and treatment plans for future health care. Requesting medical records is a significant operating component in successfully resolving claims issues with regard to BlueCard. IBC recognizes the complexity of the process as a whole and works diligently to create a more seamless transition when requesting and receiving medical records from our provider community. It is important that providers are aware of the guidelines that support the medical records request process as well as what instances constitute the needs for medical records from providers.

Please review the following guidelines regarding medical record requests:

- Medical records are stored in a secure manner accessible to authorized personnel only. Protected Health Information is protected against unauthorized or inadvertent disclosure. The staff also receives periodic training in confidentiality of member information.
- Medical records are safeguarded against loss or destruction and are maintained according to state requirements. Providers must maintain all medical records in accordance with the terms of their Provider Agreement.
- Subject to applicable state or federal confidentiality or privacy laws, IBC or its designated representatives, and designated representatives of local, state, and federal regulatory agencies that have jurisdiction over IBC, will have access to provider records on request at the provider's place of business during normal business hours — or to inspect, review, and copy those records at no cost to the plan.
- When requested by IBC or its designated representatives, or designated representatives of local, state, or federal regulatory agencies, the provider will produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested time frame. If requested, the provider will submit to examination under oath regarding them.
- The initial request for medical records is generated from the member's Home Plan through BlueSquared®, a Web-based application that facilitates Inter-Plan business processes in real time.



Requests for medical records

A Home Plan may request medical records for a variety of reasons. For example, when a claim results in an appeal, medical records may be required to finalize the claim. There are 33 categories of medical records (e.g., history and physical, operative notes, lab reports), and a Home Plan may request multiple records at a time.

When IBC requests medical records, a letter is mailed to the provider indicating that the type of records required and specifies the address where the medical records should be returned. When IBC receives the medical records from a provider, they are sent to the Home Plan for review. A determination is made on how to proceed with the processing of the claim. If a Home Plan requests medical records from IBC, the request is validated to ensure that there is not a duplicate request on file.

If you have questions about requesting medical records, please contact your Network Coordinator. ❖

Additional resources

- For HMO and PPO BlueCard® facility claims, call IBC 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 Independence Blue Cross and its affiliates (IBC). Suggestions are welcome.

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NaviNet® is a registered trademark of NaviNet, Inc.

An affiliate of IBC holds a minority interest in NaviNet, Inc., an independent company.



Inter-Plan escalation process assists with timely and efficient resolution of BlueCard® claims

In 2005, the Blue Cross and Blue Shield Association (BCBSA) required Plans to implement an escalation process to assist with timely and efficient resolution of BlueCard issues. The BCBSA and Plans continue to re-evaluate the requirements and identify additional opportunities to strengthen and refine the resolution process.

Each Plan must adhere to specific guidelines within the escalation policy implemented by the BCBSA. Prior to escalating issues, Plans are expected to pursue all day-to-day procedures, which may include proactive inventory management and follow-up for claims and inquiries with partner Plans. Plans must establish, enforce, and re-evaluate the steps involved prior to escalation. The escalation process should be initiated if these efforts have been exhausted and were unsuccessful at resolving the issue. This determination to escalate an issue is made by either the member's Home Plan or the provider's local Host Plan.

Approximately 98 percent of BlueCard claims are processed and paid without an examiner's assistance or adjustment. However, the remaining 2 percent represent the volume of claims that require manual processing. IBC manages BlueCard claim inventory daily and has a team of representatives working to review claims adjustments as the initial alternative to escalating a claims issue. The escalation process is a vehicle that serves as an aid to the provider and assures proper claims adjudication when the initial sources of resolution were unsuccessful.

The escalation process is a two-level progression designed to provide a means of escalating and achieving resolution on outstanding Inter-Plan issues. The following information lists the levels and exceptions:

- Both the Level 1 and Level 2 escalation processes require acknowledgment from the Plan causing the interference within 24 hours.
- Level 1 requires resolution within ten business days.
- Level 2 requires resolution within five business days.
- Exceptions are made if the issue is related to a system problem. In this case, the two Plans would develop an agreeable solution together; the solution is then communicated to the provider.
- If the issue cannot be resolved by either the Level 1 or Level 2 escalation process, a written request must be submitted by either plan to the BCBSA. This written request, which serves as a last resort, is known as the dispute process and requires resolution of the issue within three business days.

Please contact your Network Coordinator for the status of an escalation or to inquire about whether a claims issue can be escalated. ❖