

INSIDE **ipp**

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Highlights of the BlueCard® provider education seminars

In June, we hosted two ancillary provider education seminars to review topics such as eligibility, precertification/preauthorization, problem resolution, and BlueCard updates. The seminars also included provider satisfaction improvement initiatives, a NaviNet® web portal demonstration, and a detailed presentation of the information below.

Approximately one out of three Americans (32.2 percent) receive their health insurance through a Blue Cross® Blue Shield® Plan, and about 18 percent of Blue Plan members residing in Southeastern Pennsylvania are out-of-area members of other Blue Plans. This high utilization reinforces the need to continuously expand and improve our relationships with participating providers.

Improving the provider experience with the BlueCard Program is a goal of all Blue Plans. Ongoing surveys to gauge provider satisfaction with the BlueCard Program are conducted by the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield plans.

The Blue Plans, in an active effort to improve the provider experience with BlueCard, have implemented technology enhancements to facilitate timely resolution of provider claims appeals.

Ongoing Plan partnerships to enhance provider satisfaction, along with collaborative efforts with local hospital and associations on a regular basis, are initiatives currently in place. In the future, more focus will be placed on non-acute care institutional providers. We are working with other Blue Plans in our region to develop strategies that better support providers.

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Highlights of the BlueCard® provider education seminars (continued from page 1)

The following guidelines were discussed as ways to improve the BlueCard experience:

- Verify that the most recent ID card is on file.
- Submit all institutional claims to IBC.
- Do not send duplicate claims.
- Check claims status through NaviNet.
- Submit medical records, if requested by IBC, in a timely manner.
- Obtain Coordination of Benefits information from the member and send it to IBC.

NaviNet

A key agenda item at the seminars was the BlueExchange® Out of Area option on the Plan Transactions menu on NaviNet. Details about the three transactions within this option — Claim Status Inquiry, Eligibility and Benefits Inquiry, and Referral/Auth Submission — are listed below.

- **Claim Status Inquiry.** This transaction allows providers to acquire up-to-date claims status information for an out-of-area member for whom a claim has been submitted from a local provider's office.
- **Eligibility and Benefits Inquiry.** This transaction allows providers to submit inquiries on out-of-area members in real time. A recent enhancement allows providers to use procedure codes as part of the criteria when searching for a member's benefits information.
- **Referral/Auth Submission.** This transaction allows providers to submit referral and authorization requests for out-of-area members. All BlueExchange transaction requests submitted by the provider performing the inquiry or submission are routed from NaviNet to the member's Home Plan. The member's Home Plan then transmits the requested member information through NaviNet.

Our development team continues to work with the BCBSA and NaviNet to enhance the functionality of the BlueExchange transactions and the provider experience.

Based on the feedback we received from the providers who participated in the seminars, the information presented was considered valuable and the meetings were a success. We would like to thank everyone who attended the seminars, and we look forward to continued collaboration with our provider network. ❖

Quick tips for out-of-area claims processing

We strive to process claims quickly and accurately. By following these helpful tips, you can improve your claims experience and ensure timely processing:

- **Ask members for their current member ID card.** Photocopy member ID cards regularly (front and back). Having a copy of the current ID card on file ensures that you submit claims with the appropriate member information (including alpha prefix) and helps avoid unnecessary claims payment delays.
- **Check eligibility and benefits.** Check this electronically through NaviNet or by calling [1-800-676-BLUE](tel:1-800-676-BLUE). Be sure to have the member's alpha prefix available.
- **Indicate on the claim any payment you collected.** Indicate the payment collected from the patient on the 837 electronic claim submission form or on the CMS-1450 (UB-04) form in field location 54: Prior Payments.
- **Submit all claims to IBC.** Be sure to include the member's complete ID number when you submit the claim. This includes the 3-digit alpha prefix. Claims with incorrect or missing alpha prefixes and member ID numbers cannot be processed correctly.
- **Other Party Liability (OPL) information.** In cases where there is more than one payer and a Blue Cross® Blue Shield® Plan is a primary payer, submit OPL information with the Blue Cross and/or Blue Shield claim. Upon receipt, we will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment, and we will reimburse you for services.
- **Do not send duplicate claims.** Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- **Check claims status.** Submit an electronic HIPAA 276 transaction (claims status request) or call us at [1-800-676-BLUE](tel:1-800-676-BLUE).

If you have any questions about claims filing for BlueCard members, contact your Network Coordinator. ❖

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. Our request for medical records is a significant operating component in successfully resolving claims issues with regard to the BlueCard Program. We recognize the complexity of the process as a whole and work diligently to reach our targeted goal — to create a more seamless transaction when requesting and receiving medical records from providers. It is important that providers are aware of the guidelines that support the medical records request process, as well as what instances require the need for medical records from providers.

- Medical records are stored in a secure manner that allows access to authorized personnel only. Protected health information is protected against unauthorized or inadvertent disclosure, and our staff receives periodic training in the 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 having jurisdiction over IBC, shall have access to provider records, on request, at the provider's place of business during normal business hours to inspect, review, and make copies of such records at no cost to the Plan.
- When requested by IBC, our designated representatives, or designated representatives of local, state, or federal regulatory agencies, the provider shall produce copies of any such records and will permit access to the original medical records for comparison purposes within the requested time frames. If requested, the provider shall submit to examination under oath regarding the same.
- The initial request for medical records is generated from the member's Home Plan through BlueSquared®, a Web-based application that allows plans to communicate and transmit data in real time.

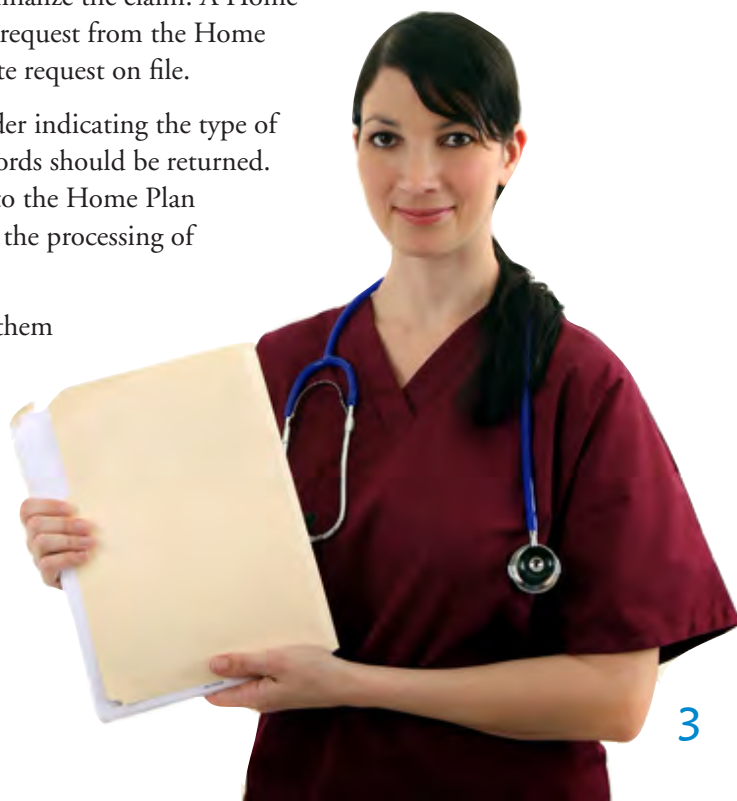
Requests for medical records

There are several reasons why a Home Plan may request medical records. For example, when a claim results in an appeal, medical records may be required to finalize the claim. A Home Plan may request multiple records at a time; upon receipt of the request from the Home Plan, IBC validates the request and assures there is not a duplicate request on file.

When we request medical records, a letter is mailed to the provider indicating the type of records required and indicates the address where the medical records should be returned. When we receive medical records from a provider, they are sent to the Home Plan for review, and a determination is made on how to proceed with the processing of the claim.

If you receive a request for medical records from us, please send them to the following address:

Independence Blue Cross
c/o Plan-to-Plan Service Unit
1901 Market Street SG-2
Philadelphia, PA 19103 ❖



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.

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Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.



HIPAA 5010 requirements and objectives for provider offices

The Health Insurance Portability and Accountability Act (HIPAA) requires providers to adopt specific standards for electronic health care transactions (e.g., claims, eligibility inquiries, claims status requests, and responses). The current version is 4010A1, but federal regulation mandates that this version be replaced with the new 5010 version by January 1, 2012. On this date, providers and vendors must use the HIPAA 5010 electronic format to submit information to IBC and other payers.

The timeline to adopt the new version may appear to be distant, but providers and vendors will need to make significant systems changes in advance to prepare for this mandatory conversion. At a high level, providers and vendors must meet three objectives:

- Providers should have already identified the differences between 4010A1 and 5010 transactions and determined what applications, systems, and operating protocols need to change. If this has not been completed yet, providers and vendors should begin this process now.
- Providers should implement changes to systems and protocols and test the changes by the end of 2010.
- Providers should schedule and complete tests with external partners and transition with them to the 5010 transactions by January 1, 2012.

If you have questions about 5010, please contact your Network Coordinator. ❖

Claims processing results for 2009

Processing claims in a timely and accurate manner is a complex process, and we work diligently each day to provide quality service and to process and pay claims within 30 days. Did you know that in 2009 we processed and paid 99.4 percent of claims within 30 days? That's more than 684,000 claims.

At IBC, we take several measures to help ensure successful claims processing, including:

- staff access to an inventory tracking tool that captures all claims that impact inter-Plan claims timeliness;
- an established threshold of 20 days to conduct outreach to partner plans by phone and email;
- several touch-point sessions each week to assess inventory and status.

As always, we hope to continue our goal of improving our claims processes and providing quality service to you. ❖