

INSIDE **ipp**

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Misrouted claims from providers

According to a policy from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans, when a Home Plan receives a claim directly from a provider outside the service area (or a clearinghouse acting on behalf of the provider) for services rendered in another Plan's service area, the Home Plan can consider the claim a "misroute."

The misrouted claim must be forwarded to the appropriate Host Plan or returned to the provider as specified by the policy. The Plan will handle the claim as follows:

- **Home Plan.** Within five calendar days, the Home Plan will do one of the following:
 - Create and send an electronic "Misrouted Claim" transaction to the Host Plan with the claim attached.
 - Return the claim to the provider or clearinghouse with notification that it must be re-filed with the appropriate Host Plan — usually the provider's local Plan — for processing. This notice will include enough information for the provider to identify the original claim submission.
- **Host Plan.** The Host Plan will file the claim through the BlueCard® inter-Plan platform.

Helpful claim-filing tips for providers

- ✓ Always ask members for their current member ID card, and regularly obtain new photocopies (front and back). Having copies of the current ID card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- ✓ Check eligibility and benefits by calling [1-800-676-BLUE](tel:1-800-676-BLUE) and providing the alpha prefix. Or send an electronic eligibility inquiry (HIPAA transaction 270) to the local Host Plan using the NaviNet® web portal.
- ✓ Providers who do not contract with any Plan are not in the BlueCard Program. Therefore, these providers should submit claims to the local Plan, which should forward the claim to the appropriate Home Plan. ❖



Blue Distinction Center designations

Blue Distinction is a designation awarded by Blue Cross® and Blue Shield® companies to medical facilities that have demonstrated expertise in delivering quality health care under objective selection criteria. The designation is based on rigorous, evidence-based selection criteria established in collaboration with recommendations from expert physicians and medical organizations. The goal of Blue Distinction is to help members find quality specialty care on a consistent basis while enabling and encouraging health professionals nationwide to improve the overall quality and delivery of health care.

The Blue Distinction designations that follow are a key part of the Blue effort to collaborate with physicians and facilities to improve the overall quality and affordability of specialty care. For more information, please visit www.bcbs.com.

Blue Distinction Centers Bariatric Surgery®

These facilities provide a full range of bariatric surgical care services, including inpatient care, post-operative care, follow-up, and patient education. Stringent quality criteria are established by expert physician panels, surgeons, behaviorists, and nutritionists.

Blue Distinction Centers Cardiac Care®

These facilities provide a full range of cardiac care services, including inpatient care, cardiac rehabilitation, cardiac catheterization (including percutaneous coronary interventions), and cardiac surgery (including coronary artery bypass graft surgery). Stringent quality criteria are established by expert physician panels and national organizations.

Blue Distinction Centers Complex and Rare Cancers®

These facilities have received their designation based on surgical case volume for adults with certain complex and rare cancers, as well as structure and process criteria. There is evidence that supports that, for many complex and rare cancers, higher surgical volume is related to improved patient outcomes. The first phase of the program assesses facilities on evaluation, treatment planning, complex inpatient care, and major surgical treatments — all delivered by multidisciplinary teams with distinguished expertise and subspecialty training for complex and rare cancers.

While this designation is meant as a comprehensive indicator of quality, facilities are required to submit data on each of the individual cancer types as part of the evaluation process. The cancers were split into two groups based on the strength of available evidence and, to a lesser extent, rarity of the cancer type. The cancer types with stronger evidence were weighed more heavily during the evaluation process.

Blue Distinction Centers Knee and Hip Replacement®

This new designation is awarded to medical facilities exhibiting a commitment to quality care resulting in better overall outcomes for patients who undergo knee and hip replacements. These facilities have demonstrated experience in comprehensive inpatient knee and hip replacement services, including total knee and hip replacement. Candidates must submit clinical data to establish that they meet objective, evidence-based thresholds for clinical quality.

Blue Distinction Centers Spine Surgery®

This is also a new designation awarded to facilities exhibiting a commitment to quality care resulting in better overall outcomes for spine surgery patients. These facilities have demonstrated experience in offering comprehensive inpatient spine surgery services, including discectomy, fusion, and decompression procedures. Candidates must also submit clinical data to establish that they meet objective, evidence-based thresholds for clinical quality.

Blue Distinction Centers for Transplants®

For this designation, the following transplant types are examined:

- heart
- lung (deceased and living donor)
- combination heart/lung
- liver (deceased and living donor)
- simultaneous pancreas kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/stem cell (autologous and allogeneic)

Additional value-added services provided within this network include global pricing, financial savings analysis, global claims administration support, and support services like referral management, patient satisfaction survey reports, and transplant-related education programs for Blue companies. ❖

Medical policy and precertification requirements for out-of-area members

Being aware of precertification requirements is crucial for both members and providers. And because providers typically obtain precertification on behalf of members, it is important that they have easy access to information about these requirements. In the BlueCard® environment, medical policy and precertification requirements are the Home Plan's responsibility; however, related to BlueCard, local providers are often unaware when the Home Plan's medical policy or precertification requirements are different from the local Plan's requirements.

The Blue Cross and Blue Shield Association (BCBSA) continues to explore consistent medical policy among Plans as a long-term project. In the interim, the Medical Policy Router went into effect October 1, 2010, to give providers easy access to medical policy and precertification requirements. Using the NaviNet® web portal, you now can be routed to the Home Plan's website that contains its medical policies and general precertification requirements. This transition happens seamlessly based on the alpha prefix of the Plan.

To view medical policy and precertification requirements for out-of-area Blue members through NaviNet, select *Medical Policy/PreCert Inquiry* from the *BlueExchange® Out of Area* option in the Plan Transactions menu.



To conduct a search, select *Medical Policy or Pre-Certification* from the drop-down menu under “Type of Inquiry.” Simply enter the alpha prefix noted on the member’s ID card and select *Submit*.



The information that will be displayed is provided by the member’s Home Plan. If you have any questions regarding the information, please contact the member’s Home Plan. ❖

Glossary of BlueCard® Program terms

The BlueCard-related terms listed below are frequently referenced in *Inside IPP* and in other communications.

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

BlueCard Access® (1-800-810-BLUE). BlueCard Access is a toll-free number that providers and patients can use to locate health care providers in another Blue Plan's service area. This number is useful when providers need to refer a member to a physician or health care facility in another area.

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

BlueCard® PPO. BlueCard PPO 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. Members with this identifier can access the benefits of BlueCard PPO.

BlueCard Worldwide®. This program allows Blue members who are traveling or living abroad access to covered inpatient hospital care and 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.

Consumer-directed health care/health plans.

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

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

Coordination of benefits. Coordination of benefits (COB) allows a member 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 multiple health care plans, one plan is determined to be primary, and its benefits are applied to the claim first. Reimbursement of the balance is through the secondary and/or tertiary policy, subject to benefits 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 benefits 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, or Medicare Savings Account plan. It generally offers Medicare Part D (prescription drug coverage).

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 work only with the Original Medicare Plan. *Note:* A Medicare Advantage plan is not a Medigap policy.

National account. This employer group contains employees and/or retirees 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 claims 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 COBs, Medicare, workers' compensation, subrogation, and no-fault auto insurance.

Plan. This term refers to any Blue Plan. ❖

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**Danielle Mittermaier**

Managing Editor

**Provider Communications
Independence Blue Cross
1901 Market Street, 35th floor
Philadelphia, PA 19103**

InsideIPP@ibx.com

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Mental health and substance abuse benefits changes for FEP members

Effective January 1, 2011, the following changes were made to the mental health and substance abuse benefits for the Federal Employee Program (FEP):

Copayment waiver for prepartum and postpartum depression visits

The copayment is waived for up to four visits for members who are seeking treatment for prepartum and postpartum depression. This applies to both the Standard and Basic Option for outpatient facility services incurred on or after January 1, 2011. Up to four copayments will be waived when claims are billed with diagnosis codes 648.40, 648.41, 648.42, 648.43, and 648.44.

Residential treatment centers

Residential treatment centers (RTC) will no longer be treated as covered providers. Changes will be put in place to discontinue preferred mental health/substance abuse benefits for inpatient facility claims submitted by RTCs unless they are provided and approved under the case management process. This applies to both the Standard and Basic Option for claims incurred on or after January 1, 2011, with a type of bill equal to 086X or have a revenue code equal to 1001 or 1002.

Obtaining prior approval

The requirement that prior approval must be obtained before payment is made for any outpatient facility mental health/substance abuse benefit is being removed. This includes partial hospitalization programs and intensive outpatient programs at preferred or non-preferred facilities. This applies to both the Standard and Basic Option for services incurred on or after January 1, 2011.

If you have any questions about these changes, please contact your Network Coordinator. Please note that these changes were originally communicated in the December 2010 edition of *Partners in Health Update*SM, which is available at www.ibx.com/PIHUpdate under Archived Issues. ❖

