

# INSIDE **ipp**

AN INTER-PLAN PROGRAMS PUBLICATION



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## *Inside IPP* turns three

This spring marked the three-year anniversary of the launch of *Inside IPP*, which was designed to answer your questions about Blue Cross and Blue Shield Inter-Plan Programs, including BlueCard® and Medicare Advantage.

With this publication, we have also been able to keep you informed of new or updated Inter-Plan Program initiatives and provide up-to-date claims filing and instructional information. Our goal is to continue to improve your overall experience with BlueCard and Medicare Advantage processing and interaction with Independence Blue Cross and other independent Blue Cross® and Blue Shield® Plans.

Your input is of great value to us, and we welcome and appreciate any feedback you may have regarding *Inside IPP*. Is there a topic you would like us to address in a future edition? Do you have a suggestion on how we can better communicate this information to you? Send us an email at [InsideIPP@ibx.com](mailto:InsideIPP@ibx.com), and let us know what you think! ❖

## Billing for outpatient pharmacy/injectable claims

We have identified an increase in incorrectly billed outpatient pharmacy/injectable claims. With the spike in errors, we'd like to address the potentially confusing situation.

When billing for outpatient pharmacy/injectable services, providers must bill using the most appropriate CPT® or HCPCS code. Unlisted and/or non-specific CPT or HCPCS codes are acceptable only for drugs that do not have a more specific code available. We have identified a high volume of claims billed with an unlisted and/or non-specific code; however, based on the submitted National Drug Code, they should have been billed with a more specific CPT or HCPCS code. We will continue to retract erroneous payments for outpatient claims being billed incorrectly with unlisted and/or non-specific CPT or HCPCS codes when a more specific code was available.

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

## Change to invoices for certain implantable devices

We recently changed how invoices should be submitted for certain implantable devices, as communicated through a provider bulletin earlier this year. For implantable devices that are purchased on consignment or in bulk (e.g., drug-eluting stents), IBC will no longer require that the lot number and/or serial number of implantable devices on implant records match the manufacturer's invoice.

IBC requires the following documentation for these implantable devices:

- a representative copy of the manufacturer's invoice that reflects the cost per unit, units per order, and model number and/or clear description of the implantable device;
- the implant record, including the model number and/or clear description of the implantable device;
- the patient-specific serial number of the implant recorded in the implant record.

IBC reserves the right to audit invoices and medical records to ensure that the submitted invoice reflects acquisition costs. The changes reflected will be incorporated into the Billing & Reimbursement for Hospital Services section of the *Hospital Manual for Participating Hospitals, Ancillary Facilities, and Ancillary Providers*.

Please contact your Network Coordinator if you have any questions about billing for implantable devices. ❖

## Updated payer ID grids available

The professional and facility payer ID grids were recently updated to include new alpha prefixes for account-specific National BlueCard® PPO members.

Please be sure to use the most current version of the payer ID grids, which are available on our website at [www.ibx.com/edi](http://www.ibx.com/edi). ❖

## BlueExchange®: Enhancing the BlueCard business process

BlueExchange, developed by the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, enhances the efficiency of the BlueCard business process. BlueExchange is an electronic solution that provides HIPAA compliance for Inter-Plan transactions and allows for electronic communication between providers and a member's Home Plan.

BlueExchange is accessible through the NaviNet® web portal or through other trading partners that support eligibility and benefits requests. Through NaviNet, providers can access information regarding member eligibility, benefits (including remaining amounts), and claims status (including claim adjustment status) as well as submit referrals and authorizations for out-of-area members. For the majority of BlueCard requests, responses to such inquiries will come from the member's Home Plan.

When submitting a referral or authorization through BlueExchange, the member's Home Plan will generally respond by contacting the originator of the request by fax, telephone, or written confirmation. Please note that the response transmitted is based on the member's coverage, eligibility, and account information on file at the Home Plan for either the date that the request is initiated or the date of service on the request.

*Note:* In order for this process to work, the member's three-digit alpha prefix (as shown below) must be included as part of the ID number when the inquiry is submitted.

ABC1234567	ABC1234H567	ABC1234H5678901234
⏟	⏟	⏟
Alpha prefix	Alpha prefix	Alpha prefix

The alpha prefix is a critical component, as it is used to route the inquiry to the appropriate Home Plan. Without the alpha prefix, an inquiry will *not* be generated because the correct Home Plan cannot be identified to respond to the inquiry. ❖

## Medical record requests and resolving 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 these records is a significant operating component in successfully resolving BlueCard claims issues.

We recognize the complexity of this process and continue working towards a more seamless transition for requesting and receiving medical records from our provider network.

### Medical record request guidelines

It is important that providers are aware of the guidelines that support the medical records request process. Please review the following:

- Medical records should be stored in a secure manner accessible to authorized personnel only, with Protected Health Information (PHI) safe against unauthorized or inadvertent disclosure.
  - Office staff should receive periodic training about the protection and confidentiality of member PHI.
  - Medical records should be safeguarded against loss or destruction.
  - Medical records should be maintained according to state requirements and in accordance with the terms of your Provider Agreement.
  - Subject to applicable state or federal confidentiality or privacy laws, IBC or its designated representatives, or designated representatives of local, state, and federal regulatory agencies that have jurisdiction over IBC, must be allowed access to provider records on request at the provider's place of business during normal business hours 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, providers must produce copies of any such records and 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 the medical records.
  - The initial request for medical records will be generated from the member's Home Plan through BlueSquared®, a Web-based application that facilitates Inter-Plan business processes in real time.

### Process for medical record requests

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 different categories of medical records (e.g., history and physical, operative notes, lab reports), and a Home Plan may request more than one category at a time.

When IBC requests medical records, a letter will be mailed to the provider indicating the type of records required and specifying the address where the medical records should be sent. When IBC receives medical records from a provider, they are sent to the Home Plan for review. A determination is then made on how to proceed with the processing of the claim.

*Note:* When 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 requests for medical records, please contact your Network Coordinator. ❖

**Additional resources**

For HMO and PPO BlueCard® facility claims, call **1-800-ASK-BLUE**.

For questions about 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.

**CONTACT INFORMATION****Danielle J. Fisher***Managing Editor*

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

*InsideIPP@ibx.com*

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## Distinguishing an outpatient stay from an inpatient visit for FEP members

IBC has noticed that there is some confusion in distinguishing an outpatient stay from an inpatient visit for Federal Employee Program (FEP) members. Below is a scenario that may help with some of this uncertainty.

**Scenario:** *A patient is in a hospital room. He came to the hospital for surgery or to the emergency room for emergency care. He was put in a room with a telephone and television and in a bed that goes up and down. He has a hospital bracelet with his name and room number, and nurses and hospital staff provide him with care. He is also receiving daily menus and prescribed meals. While it may appear that he is receiving inpatient care, the hospital may have classified his stay as observation care, which should be billed as outpatient. Has anyone told the patient?*

For our FEP members, claims for care received are paid based on the type of care that the provider bills, the provider's network status, and the member's benefits. "Standard Option" FEP members will be responsible for at least 15 percent of the allowance for all the outpatient services provided, which can be considerably more than the \$250 copayment that they would be responsible for as an inpatient. While we do not encourage providers to admit FEP members to the hospital as inpatients if their care can be safely provided in an outpatient setting, we do encourage you to educate your patients, our members, about their admission status.

Many providers have a process of communicating this information to FEP members. For those who do not, please see the following script, which can be given or read to FEP members when their admission status is determined:

*"Thank you for choosing [insert your facility]. You have been placed into an outpatient care status for either (1) outpatient observation or (2) continued care following an outpatient surgery. You are still considered an "outpatient" but are being cared for in a bed on a nursing unit to allow your physician to further evaluate your symptoms. Your classification as an outpatient will not alter your treatment.*

*Within 24 hours, your physician should decide to do one of the following:*

- *admit you for inpatient treatment*
- *discharge you for continued outpatient follow-up care*

*It is important for you to understand that, as an outpatient, you are responsible for any out-of-pocket expenses, such as copayments, deductibles, and certain medications, in accordance with your FEP health care plan. If you have questions about your health care coverage, please call the Customer Service number on your member ID card."*

If you have questions about distinguishing between outpatient stays with observation and inpatient visits for FEP members, call **1-800-ASK-BLUE**. If FEP members are uncertain about their admissions status or costs associated with their admission status, please have them call the Customer Service number on their member ID card. ❖