

INSIDE **ipp**

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Expediting medical record requests from the Host Plan

When a Host Plan receives a request for medical records from a Home Plan, it is very important that the records be sent in a timely manner to ensure that the provider is reimbursed and the services rendered by the out-of-area member are covered appropriately.

To expedite the handling for Host Plan medical record requests, please adhere to the following tips and guidelines:

- Medical records are processed quickest when they are submitted by fax or email.
- Only the medical records that have been requested should be sent.
- Unsolicited medical records cannot be forwarded to another plan by IBC.

Host Plan medical records can be sent in any of the following ways:

- **Fax.** Medical records can be securely faxed to [215-238-7915](tel:215-238-7915).
- **Email.** Medical records can be emailed to bluesquaredhostmedicalrecords@ibx.com.
- **Mail.** If you do not have access to fax or email, you can send medical records by mail on a CD or in hardcopy. Please mail the medical records to:

Host Medical Records Department
1500 Spring Garden Street
Philadelphia, PA 19130

Note: This information does not apply to medical record requests directly from a Home Plan or to appeals. ❖

Precertifying additional days for inpatient hospital stays

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 diagnosis related group (DRG)/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 potential payment denials and application of a precertification penalty on the member.

To avoid precertification penalties for members, it is important to check that additional days were precertified *before* a patient is discharged, as some national accounts may require concurrent review for out-of-area members, regardless of DRG status.

Providers may also contact the member's Home Blue Plan for approval on his or her behalf. To do so, call the BlueCard Eligibility® line at 1-800-676-BLUE and ask to be transferred to the utilization review area.

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. ❖

2011 provider satisfaction survey results

Each year we conduct a survey to assess our hospitals' satisfaction with BlueCard and to learn ways to improve our processes. The results from the 2011 survey show that overall satisfaction is at 76.5 percent, above the system average for Blue Plans.

Thank you for your valuable feedback over the years. Since 2009, we have improved our overall satisfaction score by over 20 percent through:

- greater emphasis on provider education with face-to-face and group learning sessions;
- increased efforts with other independent Blue Plans to address common issues.

We hope to continue finding ways to improve our processes and welcome your constructive feedback. If you have ideas for further improvements, please contact your Network Coordinator and that information will be directed to the appropriate department. ❖

Reminder: Check member ID cards

With the start of the New Year, we encourage you to remind the administrative staff in your office to ask all patients if they have a new Blue ID card and to obtain a copy of the member ID number.

If the member's ID number or plan has changed in any way (e.g., new alpha prefix), this exercise will help to speed the claim adjudication process. ❖

Change to mass adjustments for outpatient fee schedule changes for IBC claims

In accordance with direction from the Blue Cross and Blue Shield Association (BCBSA), mass adjustments for outpatient fee schedule changes for IBC member claims will no longer directly crossover from the Centers for Medicare & Medicaid Services to IBC.

When you receive the remittance advice from Medicare, you will be able to confirm whether the claim has been automatically forwarded (crossed over) to IBC. If the remittance indicates that the claim was not crossed over, submit the claim to IBC electronically with Frequency Code 7 to indicate the claim is a replacement of a prior claim.

The following are additional frequency codes that you may need when submitting a claim:

- Frequency Code 5: For late charges only
- Frequency Code 8: Void/cancel a prior claim

Please contact your Network Coordinator if you have any questions about this change. ❖

Updated payer ID grids now 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 at www.ibx.com/edi. ❖

www.ibx.com/providers

The importance of the *Coordination of Benefits Questionnaire*

We strive to streamline claims processing and reduce the number of denials related to coordination of benefits (COB). As such, we would like to advocate that all out-of-area* Blue Cross and/or Blue Shield members complete the *Coordination of Benefits Questionnaire* prior to services being rendered.

When a completed *Coordination of Benefits Questionnaire* is on file, we are able to speed the claims process and minimize delays in payment to providers. While the overwhelming majority of Blue Plan members across the country have coverage with a “pay and pursue” approach to COB and other insurance, some large, self-funded national accounts require that their Blue Home Plans take a “pursue and pay” approach. This approach requires claims to be pended until the patient completes the *Coordination of Benefits Questionnaire*.

Instructions for completing the form

The questionnaire is available on our website at www.ibx.com/providers/claims_and_billing/bluecard or through the NaviNet® web portal by selecting *BlueCard COB Questionnaire* from the *BlueExchange® Out of Area* option in the Plan Transactions menu.

The provider or office staff should complete the first two fields of the questionnaire: the provider name and NPI. Then ask the out-of-area member to complete the remaining sections of the questionnaire before he or she leaves the office. If the member chooses to complete the questionnaire outside of the office, he or she should be instructed to return the completed questionnaire to the provider's office.

Once complete, please immediately process the form by using the following options:

- **Fax.** You can fax the completed questionnaire to 215-238-7921.
- **Mail.** You can mail the completed questionnaire to the address prominently printed on the front page of the questionnaire.

If you have any questions about this important process, please contact your Network Coordinator.

Note: The *Coordination of Benefits Questionnaire* should not be used for local IBC members or Federal Employee Program (FEP) members. ❖

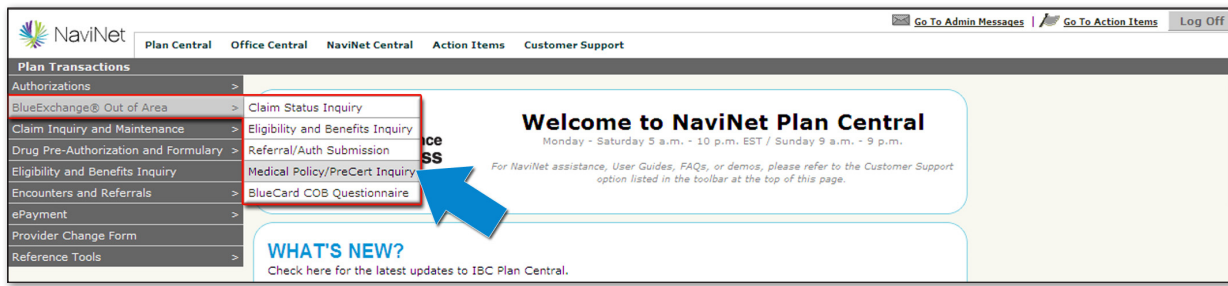
*Out-of-area members are members of other Blue Cross and Blue Shield plans who travel or live in the IBC five-county service area, which includes Philadelphia, Bucks, Montgomery, Chester, and Delaware counties.

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

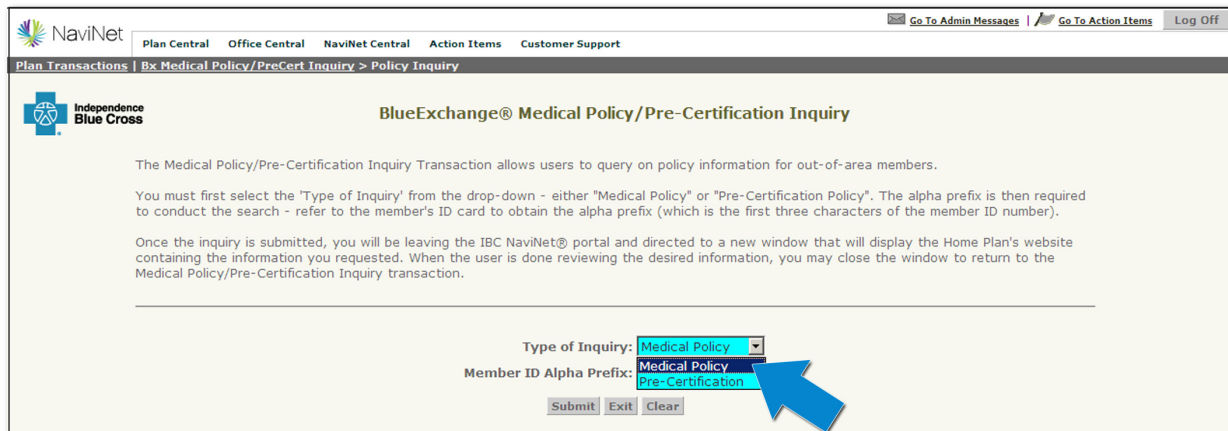
Being aware of precertification requirements is crucial for both members and providers. Because providers typically obtain precertification on behalf of members, it is important that they have easy access to information about these requirements. In the BlueCard® environment, medical policy and precertification 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.

Through the Medical Policy Router on the NaviNet® web portal, you 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, and it gives providers easy access to medical policy and precertification requirements.

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. ❖

Additional resources

For BlueCard®
facility claims, call
[1-800-ASK-BLUE](tel:1-800-ASK-BLUE).

For questions about
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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ICD | 10

More codes • More detail • Improved accuracy™

Preparing for ICD-10: Update for facility providers

ICD-10 (International Classification of Diseases, Tenth Revision) is a coding of diseases, signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases, as classified by the World Health Organization.

Currently, the United States uses ICD-9 code sets. In early 2009, the Department of Health and Human Services mandated that all covered entities* must convert to the ICD-10 code sets by October 1, 2013. The new ICD-10 code sets use updated and more precise medical terminology, include greater specificity (including a greater number of digits), and enable laterality. With the adoption of ICD-10, the number of diagnosis and procedure codes will increase significantly from roughly 24,000 codes to 140,000 codes.

The implementation of the ICD-10 coding system will have significant impacts on all areas of the health care industry and require significant operational and process changes. Providers and trading partners must prepare early for this massive shift. If providers and trading partners are not compliant with ICD-10 by October 1, 2013, IBC will not be able to process their claims. This will disrupt their payment flow.

Providers need to begin preparing now for the ICD-10 transition in order to be ready for October 1, 2013. IBC recommends the following preparation steps:

- Identify current systems and work processes that use ICD-9 codes. It is likely that wherever ICD-9 codes now appear, ICD-10 codes will take their place.
- Talk with your management system vendor about accommodations for ICD-10 codes. Contact them and ask what updates they are planning to implement for ICD-10, and when they expect to have it ready to install. Check your contract to see if upgrades are included as part of your agreement.
- Discuss implementation plans with all your clearinghouses, billing services, and payers to ensure a smooth transition. Be proactive, don't wait!
- Identify potential changes to work flow and business processes. Consider changes to existing processes including clinical documentation, encounter forms, and quality and public health reporting.
- Assess staff training needs. Identify the staff who code or have a need to know the new codes.

The implementation of ICD-10 will improve the quality of health care due to more accurate coding and diagnosis, reduced payment errors, and improved data reporting globally. ❖

*Any health plan, health care clearinghouse, or health care provider who transmits any health information in electronic or paper form in connection with a transaction covered by the Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification transaction standards.