

BlueCard® Update and Advisory March 2006

Alert:

BlueCard® identification numbers having less than 9-digits or containing alpha characters need to be submitted on paper...

We apologize in advance for this inconvenience. With the implementation of unique subscriber identification numbers, some Blue Plans began to utilize identification number having less than 9-digits or containing alpha characters. This has created a significant issue as our processing systems are set up to accommodate a nine digit alpha number only. When claims are submitted on paper, we are able to manually adjust the identification number to accommodate for the variance and process through the systems correctly. When claims are submitted electronically they automatically enter into the processing system and in most cases are inadvertently denied indicating the patient can not be identified (HIPAA adjustment reason code of 31).

We are working to update our processing system and will notify you as soon as we are able to accept these types of ID numbers electronically.

BlueCard® Survey:

2006 BlueCard® Program Satisfaction Survey... We Appreciate Your Feedback

As a participating BlueCard Program provider, your satisfaction is our top priority. Blue Cross and Blue Shield of Vermont values the care that you provide to Blue members, and, with your feedback, we can identify ways to serve you more effectively.

To continue evaluating our performance, we have asked The Response Center, an independent research company, to conduct telephone interviews on our behalf. They will contact a randomly selected sample of providers who provided care for BlueCard members during 2005. This year's survey will be administered in two waves, to give us a more up-to-date picture of your satisfaction. The first set of telephone interviews will be administered in April-May, and the second set will be scheduled the fall.

** The BlueCard Program is a national program that enables members obtaining healthcare services while traveling or living in another Blue Cross Blue Shield Plan's area to receive all the same benefits of their contracting BCBS Plan and access to providers and savings. The program links participating health care providers and the independent BCBS Plans across the country and around the world through a single electronic network for claims processing and reimbursement.*

The Response Center will ask to speak with the person in your office who is most knowledgeable about filing Blue Cross and Blue Shield claims and/or someone in the billing department. Please alert the appropriate staff in your office that they may be contacted. If you receive a call, please take a moment to participate, as your feedback is important to us.

Thank you in advance for taking the time to participate in this survey.

BlueExchange:

Get Faster and Easier Information Electronically for BlueCard® Members- Introducing our Enhanced BlueExchange Link!

Want a faster and easier service that reduces the time your office spends checking eligibility and claims status for BlueCard members?

With a few clicks of a mouse, you can access Blue Cross and Blue Shield of Vermont's electronic gateway to BlueExchange where you can:

Check Eligibility – Provides a faster way to verify eligibility and benefits for members of other Blue Plans

View Claim Status - Avoid unnecessary resubmission by checking claims status electronically for BlueCard members.

Complete Timely Electronic Transactions - Go electronic and get faster real-time responses to your inquiries for members from other Blue Plans. Most of the responses will be sent to you within 2 minutes.

Reliable Local Service - BCBSVT is your single point of contact for all inquiries.

BCBSVT created and maintains the BlueExchange web page on the BCBSVT provider web site. To access and utilize the link you will need at least version 6.0 of Internet Explorer. The BlueExchange home page provides an option for viewing or printing the BlueExchange Provider User Training Manual.

If after viewing the training manual, you feel your office needs additional training and education on the BlueExchange product, call a member of your Provider Relations Team toll free at (888) 449-0443 and schedule an on site visit.

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Claim Submission Tips:

Medicare Claims – New Crossover Consolidation Process More Claims Will Be Automatically Submitted to the Secondary Payer

How do I submit Medicare primary/Blue Plan secondary claims?

For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier. When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the member's Blue Plan:

If the remittance indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process.

There is no need to resubmit the claim to BCBSVT.

If the remittance does not indicate that the claim was crossed over, submit the claim to BCBSVT with the Medicare explanation of benefits.

To check claim status on a claim submitted to BCBSVT contact us directly (800) 395-3389 or check the BlueExchange link (see article above for details).

What is Medicare crossover consolidation and how does it affect my claim processing?

To simplify and streamline claim submission, the Centers for Medicare and Medicaid Services (CMS) is now consolidating its claim crossover process under a special Coordination of Benefits Contractor (COBC) by means of the Coordination of Benefits Agreement (COBA). Under this program, the COBC will automatically forward most Medicare claims to the secondary payer, eliminating the need to separately bill the secondary payer.

Blue Plans are now implementing the Medicare crossover consolidation process System-wide, and will continue to do so over the next few months. Once the consolidated crossover process is fully implemented, you should experience an increased level of "one-stop" billing for your Medicare primary claims.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, don't automatically submit another claim. Rather, you should:

Review the automated resubmission cycle on your claim system.

Wait 30 days.

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Check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, can actually slow down the claim payment process and creates confusion for the member.

Newly Licensed Blue Plan:

You may begin to see members from our newest Blue Cross Blue Shield International Licensee, Blue Cross and Blue Shield of Panama. BCBS of Panama members will carry BCBS ID cards with the alpha prefix VPP.

Remittance Advice Updates:

We continue to work on enhancing our Remittance Advice....

In our September 2005 update, we notified providers of our efforts to improve the reporting of BlueCard claims on remittance advices. In this issue, we are including a prior enhancement, as well as current updates.

BlueCard Claims that require additional information: An update to the HIPAA adjustment reason codes used allows you to determine whom the additional information is required from; the provider **or** the member.

If a HIPAA adjustment **reason code of 17** is applied to the explanation code column of the RA, the **Home Plan needs information from the member** (the Home Plan provides notice to the member of what information is required and how to respond). Other Party Liability Questionnaires and Dependent Student Certification Forms are examples of information the Home Plan may have requested from the member. When this explanation code is used, billed charges are the member liability.

If a HIPAA adjustment **reason code of 16** is applied to the explanation code column of the RA, the **Home Plan needs information from the provider**. Medical records, office notes or description of services are typical requests to providers. If the Home Plan needs information from you, BCBSVT will make that request on their behalf. When this explanation code is used, the member is not responsible for the charges.

Please remember to utilize these codes when posting your weekly RA(s).

RA does not balance: As a result of provider input, two recent updates have been made to the RA and one other is awaiting implementation.

Claims with partial denials: Claim lines that have a partial payment and a partial denial are now posting correctly to the RA. Due from patient amounts and appropriate HIPAA adjustment reason codes are included.

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Patient penalties not reported: Some Blue Plans assess penalties for non-compliance with Plan guidelines, such as utilization of a non-preferred or out-of-network provider or lack of required preadmission review. Enhancements have been implemented so that this information will now show in the RA with the corresponding HIPAA adjustment reason code. The dollars and explanation codes for the associated penalties are now populated appropriately.

Payment maximums are not reported: Some Plans apply payment maximums to certain member benefits. These dollars are not currently being reflected on the RA. Changes to correct this issue have been initiated. In the mean time, if you receive an RA that does not balance, please contact Customer Service at (800) 395-3389. If there is patient liability as a result of a payment maximum, a corrected RA can be sent to you.

Turn Around Times, Accuracy and Adjustment Rates:

Did you know that the average Host claim processes in 10.50 days? And Host adjustments process within 15 to 21 days, with an accuracy rate of 98%?

If you have any questions regarding the BlueCard program, or would like to obtain more information about it, please feel free to contact your Provider Relations Representative at (888) 449-0443.

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