Blue Cross and Blue Shield of Vermont and The Vermont Health Plan held Claims Operational Seminars throughout the State during September and October 2006. Below is the detail on frequently asked questions during these seminars, they have been categorized.

CLAIM RELATED ISSUES:

Q. How do I know where to submit claims for BlueCard members?

A. When you are a provider based in Vermont, all claims for BlueCard need to be submitted to BCBSVT. The only exception would be if you have a contract with another Blue Plan and you are seeing their member, than you submit the claim to the Plan you are contractually obligated to for that member population.

Q. With the change to unique subscriber identification numbers, I am encountering numerous issues with BlueCard member submissions. What is the problem?

A. Subscriber identification numbers larger or small than 9 digits, or containing alphas are not able to be submitted electronically. We did notify all providers of this in the first quarter and second quarter BlueCard Advisories. We are in the process of correcting this issue**. UPDATE:** As of 11/20/06 **ALL** BlueCard identification numbers are able to be submitted electronically.

Q. Where on your website are the surgical assist guidelines.

A. They are located on our public website (bcbsvt.com) under forms and publications, provider forms, surgical assist list 2006.

Q. Why do you recover complete claims, when there is only one line that needs to be adjusted?

A. Our system requires a complete take back of original claim and reprocessing to balance.

Q. **Does the Federal Employee Program have an automatic cross over for their secondary claims, or do they have to be submitted after Medicare processing**?

A. No, claims do not automatically cross over from Medicare at this time. This is scheduled to be automated during 2007. More details to follow.

Q. Will denials of "investigational procedure" be applied to members who have supplemental policies with BCBSVT?

A. No, the supplemental policies follow Medicare guidelines.

Q. How do Medicare cross-over's work for BlueCard Members?

A. Medicare will cross over to the member's home plan for processing. Depending on the home plan policies the member or provider may receive the payment. If after 45 days from the cross over notice you have not received a response, look up the claim on BlueExchange or place a call to our Customer Service Department, this will initiate an inquiry with the home plan.

Q. When do we need to submit Medicare supplemental claims directly to BCBSVT?

A. Paper submission for supplemental policies should be infrequent because once Medicare processes the claims; they automatically cross over the balance to the Plan for payment. Even if Medicare paid in full, the Plan receives the claim and we notify you via the Remittance Advice that Medicare paid in full, no payment is due.

Q. What do we do if a member does not give secondary information, can provider send the explanation of Medicare benefits with the claim to BCBSVT?

A. Yes, you can forward it directly to BCBSVT.

Q. Should office notes be sent with claim at original submission?
A. Unless you are directed to do so by BCBSVT, original submissions should not contain office notes.

Q. We continue to receive denials for worker comp when the member has not had a WC claim for a few years? How long is this housed in the file and what can we do to have it removed so claims do not continue to deny. It is not specific to any patient, just those who previously had a WC claim.
A. BCBSVT does not house any workers comp information in the claims adjudication system that would automatically deny a claim. If the claim submitted indicates the service provided was work related, than follow up will occur with the member.

Q. When will BCBSVT implement the new CMS 1500? Will this be required to submit National Provider Identifiers?
A. BCBSVT is in the process of developing a work plan to implement the use of CMS 1500. More details will be provided as the plan is established.

Q. If I discover the overpayment of a claim and want to refund the money, can I, or do I have to initiate a recovery and wait for the processing on a remittance advice?
A. Although the best method to refund money is through a recovery, refunds can also be made by check. When submitting make sure you submit a provider overpayment form with the check so the funds are appropriately credited back to the account.

Q. Can late charges be submitted electronically?
A. The response will vary depending on product line and type of service. Below is a break out of the requirements:

LATE CHARGES:
In order to expedite processing, late charges must be submitted as follows:
Type of bill:
Outpatient = 135 **Inpatient = 115**

Line of Business	**Outpatient Service**	**Inpatient Service**	**DRG Services**
TVHP/BCBSVT	Late Charges must be submitted electronically or as a paper submission (paper submitters only). DO NOT INCLUDE THE ORIGINAL CHARGES.	Late Charges must be submitted electronically or as a paper submission (paper submitters only). DO NOT INCLUDE THE ORIGINAL CHARGES.	DRG requires paper submission. Submit the late charges only, indicating corrected claim. A Provider Inquiry Form (PIF) is not necessary.
BlueCard	<u>Late Charges</u> Must be submitted	<u>Late Charges</u> Must be	<u>DRG requires</u> paper

	on paper (even if you are a electronic submitter) DO NOT INCLUDE THE ORIGINAL CHARGES.	submitted on paper (even if you are a electronic submitter) DO NOT INCLUDE THE ORIGINAL CHARGES.	submission(even if you are a electronic submitter) Submit the late charges only, indicating corrected claim. A Provider Inquiry Form (PIF) is not necessary.

CO PAYMENT:

Q. **When will the BCBSVT/TVHP ID cards contain the co-payment information? Not having this information on the card makes it a challenge when the patient presents for services.**

A. BCBSVT/TVHP has begun a three year project to upgrade our existing software. Part of that upgrade will provide the functionality to report co-payment information to the program that does the card generation. There will not be an immediate fix to this problem. Co-payment information can be verified by using the our provider web site, or calling into the appropriate Customer Service Department.

Q. What type of education and/or materials does the member receive regarding their co-payment?

A. Members receive an outline of coverage that defines their financial responsibility for specific services, which does include co-payment information. The outline of coverage is the same document reviewed by provider practices when utilizing the eligibility function on the provider web site.

Q. What can be done about members who refuse to bring their co-payment to the office at the time of the visit?

A. BCBSVT is limited in how we can handle these situations. Providers can call into the Customer Service Department and provide the details of the situation. Customer Service can than do a generic outreach call to the member to provide a high level overview of their benefits. (please note: several discussions occurred regarding how other practices handle this situation. Some of the practices in a non emergent situation refuse to see the patient and reschedule at another time, other charge an additional fee if the co-payment is not presented at the time of the visit.)

IDENTIFICATION CARDS:

Q. Are members issued identifications every year?

A. No, identification cards are issued to members when there is a change in there coverage (i.e., change in benefits), or they have requested new copies.

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PRIOR APPROVAL:

Q. Is there a way you can notify members that Doctors do not approve the prescriptions requiring prior approval, but the Plan and it is done within 24 hours of submission of request?

A. Yes, we will notify our Communications Department and request they run articles in our various member newsletters. November 2006 update: a request has been placed to include this information in first quarter 2007 newsletters.

Q: **For New England Health Plan Referral Authorizations, notices are only sent in the case of a denial, why? We would prefer to know either way.**

A. This practice is currently under review and maybe changed in the future.

Q. We have a patient who is involved in case management and requires several drugs on the prior approval list. Filling out each form is an administrative burden, is there one form or a process that can be followed to just make one request?

A. No, there is not one form. Each form has been designed to have very specific questions that assist in the medical decisions. Other formats can be submitted, but each of the questions for the medication being prescribed has to be responded to before a medical decision can be made.

PROVIDER NETWORKS:

Q. How do I obtain a directory for New England Health Plan providers? I do not know who they can be referred to for specialty care.

A. New England Health Plan members utilize the Vermont Health Partnership network, with the exclusion of providers located in the New Hampshire area (i.e., Dartmouth Hitchcock).

Q. What is the credentialing date based on and can it be retroactively added?

A. The credentialing date is the date a provider was approved by the credentialing committee. Credentialing can not be retroactively added.

Q. What impact will National Provider Identifiers have on the credentialing process?

A. There will not be any impact on credentialing as a result of NPI.

SPECIFIC PRODUCTS:

Q. Does BCBSVT have any involvement in Medicare Part D?

A. Yes, BCBSVT is offering 3 different Medicare Part D coverage options. BCBSVT Part D coverage is called Blue Medicare Rx.