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Overview

This section of the manual contains information about BlueCard, including a description of the program, resources to help facilitate communication between the Member's Home and the Host Plan, and requirements and tips for submitting BlueCard claims for out-of-area Members.

Out-of-area Members are Members of other Blue Cross® and Blue Shield® Plans who travel or live in the Independence five-county service area, which includes Bucks, Chester, Delaware, Montgomery, and Philadelphia counties.

About BlueCard

BlueCard is a national program through the Blue Cross and Blue Shield Association (BCBSA), an association of independent Blue Cross and Blue Shield Plans, that enables enrollees of one Commercial BCBSA Plan to obtain health care service benefits while traveling or living in another BCBSA Plan's service area. The program links participating health care Providers with the various BCBSA Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

As a participating facility or ancillary facility Provider, you are expected to render services to HMO and PPO patients, or patients with traditional hospitalization coverage who (1) are enrolled in Blue Cross and Blue Shield Plans other than those offered by Independence and (2) travel or live in the Independence five-county service area (Bucks, Chester, Delaware, Montgomery, and Philadelphia) and present to your facility for treatment. These Members are subject to eligibility verification and applicable Preapproval requirements.

For detailed information, please refer to the BlueCard section of the Independence Provider News Center at *www.ibx.com/pnc* to find communications specific to the BlueCard Program, such as billing requirements, claim submissions, Preapproval requirements, and administrative procedures.

Benefit coverage plans excluded from BlueCard

The following benefit plans are excluded from the BlueCard program:

- stand-alone dental
- prescription drugs
- Federal Employee Program (FEP)
- Medicare Advantage HMO plans (except for urgent/emergent claims)

Identifying BCBSA Plan enrollees

Enrollees in the United States

ID cards for out-of-area enrollees may include:

- an image of a suitcase with "PPO" in it
- an image of a suitcase with "PPO" and "B" in it
- an image of a blank suitcase

The main identifier on ID cards for out-of-area enrollees is the prefix. The three-character prefix at the beginning of the Member ID number is the key element used to identify and correctly route claims to the appropriate BCBSA Plan. The prefix identifies the BCBSA Plan or national

account to which the enrollee belongs and is critical for confirming an enrollee's membership and coverage.

Prior to providing services to enrollees of other BCBSA Plans, be sure to follow these procedures:

- Ask the enrollee for the most current ID card each time services are rendered. Because new ID cards may be issued to enrollees throughout the year, this will ensure that you have the most up-to-date information in the patient's file.
- Make copies of the front and the back of the ID card and share this key information with your billing staff.
- ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the ID number. You may remove spaces if the suffix is separated from the ID number by a space on the ID card. A correctly reported ID number includes the prefix and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between three and 14 numbers/letters following the prefix.

To ensure accurate claims processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with claims processing.

Note: FEP enrollees will have the letter "R" in front of their ID number instead of a prefix. These Members are excluded from the BlueCard Program.

International Licensees

BlueCard not only includes Members of Blue Plans in the United States (50 states and the District of Columbia). It also covers Blue Plan Members of international Licensees such as:

- Triple-S Salud* (Blue Cross Blue Shield of Puerto Rico)
- Blue Cross Blue Shield of the U.S. Virgin Islands*
- Blue Cross Blue Shield of Panama*
- Blue Cross Blue Shield of Uruguay*
- Blue Cross Blue Shield of Costa Rica
- GeoBlue℠* – the Blue International Solutions Licensee located in King of Prussia, PA, which provides coverage for students and expatriates of other nations while they are in the United States

**Independent licensee of the Blue Cross and Blue Shield Association.*

Members enrolled with an international Licensee can access Provider networks of Blue Licensees in the United States, as well as the networks of other international Licensees. These Members carry a Blue ID card with a prefix that has been assigned to the specific international Licensee.

The claims submission process is the same as with any other BlueCard claim. Host claims for these service areas should be sent to Independence for processing. Please treat these Members the same as domestic Blue Plan Members, and do not collect any payment from them beyond their cost-sharing amounts.

Canadian Association of Blue Cross Plans

The Canadian Association of Blue Cross Plans and its enrollees are separate and distinct from the BCBSA and its enrollees in the United States. Claims for enrollees of the Canadian Blue Cross Plans are not processed through the BlueCard Program.

Please follow the instructions on the enrollee's ID card when servicing the Canadian Association of Blue Cross Plan enrollees. These Plans include the following:

- Alberta Blue Cross
- Atlantic Blue Cross Care
- Manitoba Blue Cross
- Pacific Blue Cross
- Quebec Blue Cross
- Saskatchewan Blue Cross

Verifying eligibility and obtaining Preapproval

Verifying eligibility

To verify eligibility and coverage information for enrollees from other BCBSA Plans, please do one of the following:

- Log on to Provider Engagement, Analytics & Reporting (PEAR) portal. Within Practice Management (PM), select the *BlueExchange® Out of Area* transaction and then *Eligibility & Benefits*. Enter all required fields for the search. You will receive real-time responses to your BlueExchange eligibility requests Monday through Saturday, from 5 a.m. to 10 p.m. ET, and on Sundays, from 9 a.m. to 9 p.m. ET.
- Submit a HIPAA 270 transaction (eligibility request) electronically to Independence via Passport or HDX. You will receive real-time responses to your eligibility requests for out-of-area enrollees Monday through Saturday, from 7 a.m. to 1 a.m. ET the next day.
- Call the BlueCard Eligibility® line at 1-800-676-BLUE.
  - English and Spanish-speaking phone operators are available to assist you.
  - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than Independence. You may be transferred to a voice response system linked to customer enrollment and benefits.
  - The BlueCard Eligibility line is for eligibility, benefits, and Preapproval/Referral authorization inquiries only.

Obtaining Preapproval

Remind enrollees of the following regarding obtaining Preapproval:

- **Outpatient services.** Out-of-area Members are responsible for obtaining Preapproval from their Home Blue Plan when required for outpatient services. You may also contact the out-of-area enrollee's Plan on the enrollee's behalf.

- **Inpatient services.** For inpatient services, Providers are responsible for obtaining Preapproval from the Member's Home Plan for out-of-area Members. The out-of-area Member will be held harmless. Failure to obtain Preapproval for inpatient facility services for out-of-area Members will result in a denied claim. To avoid claim denials, be sure to Preapprove the inpatient stay and check that additional days are authorized before an out-of-area Member is discharged. If there are denied days within an approved inpatient stay, the Provider will be financially liable for the denied days and the Member will be held harmless. In diagnosis related group (DRG)/case rate situations, when the length of an inpatient stay extends beyond the Preapproved length of stay, any additional days must be Preapproved by the last day of the originally Preapproved days.

You can obtain Preapproval in one of the following ways:

- Use the BlueExchange Out of Area transaction on PEAR PM and select *PreService Review for Out-of-Area Members*.
- Call the BlueCard Eligibility line at 1-800-676-BLUE and ask to be transferred to the utilization review area.
- Submit a HIPAA 278 transaction (Referral/authorization request) electronically to Independence.

If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

Filing BlueCard claims

When you provide hospital/ancillary facility services to an out-of-area Blue Plan enrollee, the claim is considered a facility BlueCard claim. Facility BlueCard claims must be submitted to Independence. Independence is the BlueCard processor for facility services and will be your point of contact for claims-related questions.

To send claims to Independence electronically, use the 837I HIPAA transaction. The list of available ISA and GS codes to use can be found at *www.ibx.com/edi*.

For claim submission addresses to submit paper claims, refer to the payer ID grids at *www.ibx.com/edi*.

Be sure to complete all information fields in the claim. The claim cannot be processed if it is missing:

- medical record number;
- attending Physician information (including National Provider Identifier, name, tax ID, and physical address);
- name, dosage, and National Drug Code number.

Claims process flow

Below is an example of how a facility BlueCard claim flows through the BlueCard Program for processing:

- An enrollee of another Blue Plan receives services from an Independence-Participating Facility in the Independence five-county service area.
- The facility submits the claim to Independence (i.e., the local Blue Plan).

- Independence recognizes the BlueCard enrollee and transmits the claim to the enrollee's Home Plan.
- The Home Plan adjudicates the claim according to the enrollee's benefits plan.
- The Home Plan issues an Explanation of Benefits to the enrollee.
- The Home Plan transmits the claims processing results to Independence.
- Independence issues a Provider Remittance and payment to the Participating Facility Provider.

Verify the enrollee's cost-sharing amount and collect any applicable Copayment at the time of service. Indicate on the claim any payment you collected from the enrollee. For details, consult the HIPAA Transaction Standard Companion Guide at *www.ibx.com/edi*.

Do not send duplicate claims. Sending another claim or having your billing agency resubmit a claim automatically will slow down the claims payment process and creates confusion for the enrollee. If out-of-area enrollees contact you, advise them to contact their Home Blue Plan and refer them to their ID card for a customer service number. The Home Plan should not contact you directly regarding claims issues, but if someone from the Home Plan contacts you, refer him or her to Independence.

Claim status inquiries

Independence is your single point of contact for all BlueCard facility claim inquiries for dates of service up to 18 months prior to the current date. Claim status inquiries can be done by:

- **Phone.** For HMO and PPO facility claims and Traditional Hospitalization claims, call Independence at 1-800-ASK-BLUE. Hours of operation are from 8 a.m. to 5 p.m., ET, Monday through Friday.
- **PEAR PM.** Use the BlueExchange Out of Area transaction and select *Claims Search*.

Other Party Liability (OPL)

In cases where there is more than one payer and a Blue Cross Blue Shield Plan is a primary payer, submit OPL information with the Blue Cross and/or Blue Shield claim. Upon receipt, we will electronically route the claim to the Member's Blue Plan. The Member's Plan then processes the claim and approves payment, and we will reimburse you for services.

COB Questionnaire

Coordination of benefits (COB) refers to how the Blue system ensures that its Members receive full benefits and prevents double payment for services if they have coverage from two or more sources. All out-of-area Blue Cross and/or Blue Shield Members should complete the *COB Questionnaire* prior to services being rendered for the following reasons:

- streamlined claims processing;
- expedited payment to Providers;
- reduction in the number of denials related to COB;
- ability for employer groups to finalize out-of-area claims for their employees.

Instructions for completing the questionnaire

The questionnaire is available on our website at *www.ibx.com/providers/claims_and_billing/bluecard.html* or through PEAR PM by selecting *BlueCard® Coordination of Benefits* from the BlueExchange Out of Area transaction.

Business Office staff should complete the first two fields of the questionnaire: Provider name and NPI. Then the out-of-area Member should complete the remaining sections of the questionnaire before services are rendered. Immediately process the completed questionnaire by following the instructions on the form.

Note: The *COB Questionnaire* should not be used for local Independence Members or FEP Members.

If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.

Requests for medical records

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. Please note that these requests are independent of any requests that may be made by an independent company on our behalf. As outlined in your Provider Agreement, you are required to respond to requests in support of risk adjustment, Healthcare Effectiveness Data and Information Set (HEDIS®), and other government-required activities within the requested time frame.

There are several reasons why a Home Plan may request medical records from the Host Plan – Independence, in this case. For example, when a claim results in an appeal, medical records may be required to finalize the claim. A Home Plan may request multiple records at a time. Upon receipt of the request from the Home Plan, Independence validates the request and assures there is not a duplicate request on file.

Inovalon, an independent company, facilitates these requests on our behalf. A letter is mailed to the Provider indicating the type of records required and indicates the address where the medical records should be returned. When we receive medical records from a Provider, they are sent to the Home Plan for review, and a determination is made on how to proceed with the processing of the claim.

When a Host Plan Provider receives a request for medical records, it is very important that the records be sent in a timely manner to ensure that the Provider is reimbursed and the services rendered to the out-of-area Member are covered appropriately. To expedite the handling for these medical record requests, please adhere to the following tips and guidelines:

- Submit by fax or email for the quickest processing.
- Only the medical records that have been requested should be sent.
- Unsolicited medical records cannot be forwarded to another plan by Independence.

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

- **Fax.** Medical records can be securely faxed to 1-877-221-0604.
- **FedEx®.** For further instruction on returning medical records via FedEx, please call 1-800-463-3339.
- **Email.** Send medical records via secure email to *EMRServices@inovalon.com*.

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, Independence or its designated representatives, or designated representatives of local, State, and federal regulatory agencies that have jurisdiction over Independence, 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 Independence 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.

BlueExchange®

BlueExchange is an electronic solution that provides HIPAA compliance for inter-Plan transactions and allows for electronic communication between the Provider and the out-of-area Member's Home Plan. You can access BlueExchange through PEAR PM in the BlueExchange Out of Area transaction. You can also access BlueExchange through trading partners that support eligibility and benefit requests.

Using BlueExchange, you can perform the following transactions:

- **Claims Status Inquiry.** This transaction allows Providers to acquire up-to-date claims status information for out-of-area Members for whom a claim has been submitted from a local Provider's office.
- **Eligibility and Benefits Inquiry.** This transaction allows Providers to submit inquiries on out-of-area Members in real time. Providers can also use procedure codes as part of the criteria when searching for a Member's benefits information.
- **Referral/Auth Submission and PreService Review for Out of Area Members.** These transactions allow Providers to submit Referral and Preapproval requests for out-of-area Members. All BlueExchange transaction requests submitted by the Provider performing the inquiry or submission are routed from PEAR PM to the Member's Home Plan. The Member's Home Plan then transmits the requested Member information through PEAR PM.
- **Medical Policy/Pre-Certification Inquiry.** Using the Medical Policy Router, you can be routed to the Home Plan's website that contains medical policies and general Preapproval requirements. This transition happens seamlessly based on the prefix of the Plan, and it gives Providers easy access to medical policy and Preapproval requirements. To view medical policy and Preapproval requirements for out-of-area Blue Members, select *Medical*

Policy/PreCert Inquiry from the BlueExchange Out of Area transaction. To conduct a search, select *Medical Policy or Pre-Certification* from the drop-down menu under "Type of Inquiry." Simply enter the prefix noted on the Member's ID card and select *Submit*. If you have any questions regarding the information, please contact the out-of-area Member's Home Plan.

- **BlueCard Coordination of Benefits.** This transaction renders the *COB Questionnaire* that should be completed prior to rendering services.

If you need assistance using the transaction, please review the training materials on the PEAR Help Center at *www.pearprovider.com*.