Away From Home Care

An out-of-area program sponsored by the Blue Cross and Blue Shield Association available to HMO members.

Kansas City

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

Additional Modules

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Away From Home Care (AFHC)

Each section is a clickable link.

Guest Membership

Away From Home Care (AFHC) is an out-of-area program sponsored by the Blue Cross and Blue Shield Association (BCBSA) that is available to select HMO members in specific states.

AFHC enables members to receive guest membership coverage and benefits from other participating Blues plan HMOs, while temporarily residing outside of the service area for at least 90 days.

Members have access to a comprehensive range of benefits, including routine and preventive services.

Coordinators from the two Blues plan work together throughout the duration of a guest enrollment period to ensure all aspects of the program run smoothly.

Blue-Care HMO network members may obtain a guest membership if they plan to stay in the other Blues plan HMO location for 90 or more consecutive days.

Membership Types

Families Apart

When not residing with the subscriber, divorced or separated spouses and other dependents may apply for Families Apart Guest Membership. There is no administrative time limit for members to receive services from their guest HMO.

Long-term Traveler

A long-term traveler are subscribers, spouses or other dependents who are away from home for at least 90 consecutive days (3 months) but not more than 180 days (6 months).

Students

This program is ideal for qualified dependents of the subscriber who are attending school outside of their home HMO area – and not residing with the subscriber for 90 days or more. There is no administrative time limit for a member to receive services from their guest HMO.

Before applying, call to find out if the student will be residing in a covered service area.

Member Enrollment

- This service provides courtesy enrollment in a Blues plan HMO outside the member's home plan service area. The member must contact his or her home plan to confirm the out of area location participates in the AFHC program.
- Members must complete a guest application with their home plan to be considered for a guest membership.
- Coordination of the AFHC guest enrollment, PCP assignment and Blues plan billing is tracked by AFHC coordinators.
- After a Primary Care Physician (PCP) is selected, the host plan will give participating providers a membership identification card and information on how to access Provider benefits.

Coverage and Benefits

Guest members enjoy the full range of benefits/services offered by another Blues plan HMO. Covered benefits include inpatient and outpatient services and other medical care, including routine and preventive care. Guest members must select a PCP, but are free to self-refer within the Blue-Care HMO specialist Provider network.

When Blue KC functions as a host plan, guests have access to Blue-Care HMO which has high and low benefit options available. These ranges indicate the types of services that are covered. For example, high benefit options may include more services that aren't covered under the low benefit option. Blue KC will advise providers of any Away From Home Care (AFHC) guest members when they are assigned to providers.

The main Blue KC Provider Reference Guide difference between these options is member copayment amounts.

Eligibility Check

- Copayment information is on the member identification (ID) Card.
- The PCP's name and phone number is on the member's ID Card.
- A special prefix, preceding the policy number, is assigned to Blue-Care guest.

Claims

- Claims should be filed to Blue KC and payment is directed to the Provider.

If providers have questions about a patient's eligibility as a Guest member, call our Away From Home Care number (see Contact Resource Directory).

Provider Responsibility

Provider is solely responsible for patient medical decisions, care and treatment. Blue KC shall not be liable for or exercise control over the methods used by Provider in regards to the nature of treatment, risks or alternatives or the availability of other therapy, consultation or test.

Providers must evaluate each member in office or through telehealth with supporting documentation of encounter to bill services, thus establishing a physician-patient relationship. Blue KC may deny payment for healthcare services which it deems as not medically necessary, are not services or are not provided in accordance with the Provider Agreement.

Regardless of any actions taken by Blue KC within the Utilization Review process, including denial of a claim, providers are obligated to provide appropriate services to members under applicable laws and any code of professional responsibility.

Utilization Review, Appeals and Grievances

Providers need to provide timely medical records as requested and understand all aspects of the Utilization Review:

- Prior Authorization - prior review of services including: all inpatient stays that are medically necessary as well as services and supplies
- Quality Improvement - the process and outcomes of member services to ensure care is efficacious and consistent with generally accepted medical practices
- Concurrent Review - review of the medical necessity of healthcare services
- Case Management - coordination and healthcare assistance and monitoring
- Respective Review - review after the patient has received healthcare to assess reimbursement levels, consistency and adjudication

Failure to comply may result in denial of reimbursement for services. This includes the appeals and grievance procedures prescribed by Blue KC and by state and federal law. This applies for any Benefit Plan, even ones that aren't administered by Blue KC.

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