BlueCard® Program

Healthcare benefits while traveling or living in another Blue plan's service area, the program advantages and how to make filing claims easier.

Kansas City

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

Additional Modules

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BlueCard program

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Program Overview

Nationwide and International Coverage

BlueCard is a national program that enables members of one Blue plan to obtain healthcare service benefits while traveling or living in another Blue plan's service area.

BlueCard links healthcare providers with independent Blue plans across the country and in more than 200 countries through an electronic network for claims processing and reimbursement.

Advantages to Providers

The BlueCard program lets providers conveniently submit claims for members from other Blue plans, including international Blue plans.

Blue KC will be the only point of contact for all claims-related questions.

Blue KC continues to experience growth in out-of-area memberships because of our partnership with providers. We are committed to meeting all providers' needs and expectations. Working together, we can ensure patients have a positive experience.

As a participating Provider of Blue KC, providers may render services to patients who are national account members of other Blue plans and who travel or live in the Blue KC service area.

This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining prior authorization
- Filing claims
- Who to contact with questions

BlueCard Products

A variety of products and claim types may be eligible to be delivered via BlueCard, however not all Blue plans offer all of these products to their members.

Blue KC BlueCard

- PPO - Preferred Provider Organization.
- EPO - Exclusive Provider Organization.
- HPN - Blue High Performance Network.
  - BlueHPN℠ is a collaboration across the U.S. with select healthcare providers that include primary care doctors, specialists and hospitals.
  - When your BlueHPN patient needs to see a specialist or another healthcare provider it's important that you only recommend other BlueHPN healthcare providers to ensure members have full benefits
  - Use Blue KC's Doctor and Hospital Finder to identify BlueHPN healthcare providers. See the Contact Resource Directory for more information.
  - Benefits limited to emergent care at non-BlueHPN providers with BlueHPN service areas.
  - Benefits limited to urgent and emergent care at non-BlueHPN providers outside of BlueHPN service areas.

- HMO Health Maintenance Organization.
  - HMO claims are eligible to be processed under the BlueCard program or through the Away From Home Care Program.
- Medigap – Medicare Complementary/Supplemental.

Blue KC offers the Blue Medicare Advantage HMO product. See the Contact Resource Directory for information on reaching the local Blue Medicare Advantage Provider support.

BlueCard from Other Blue Plans

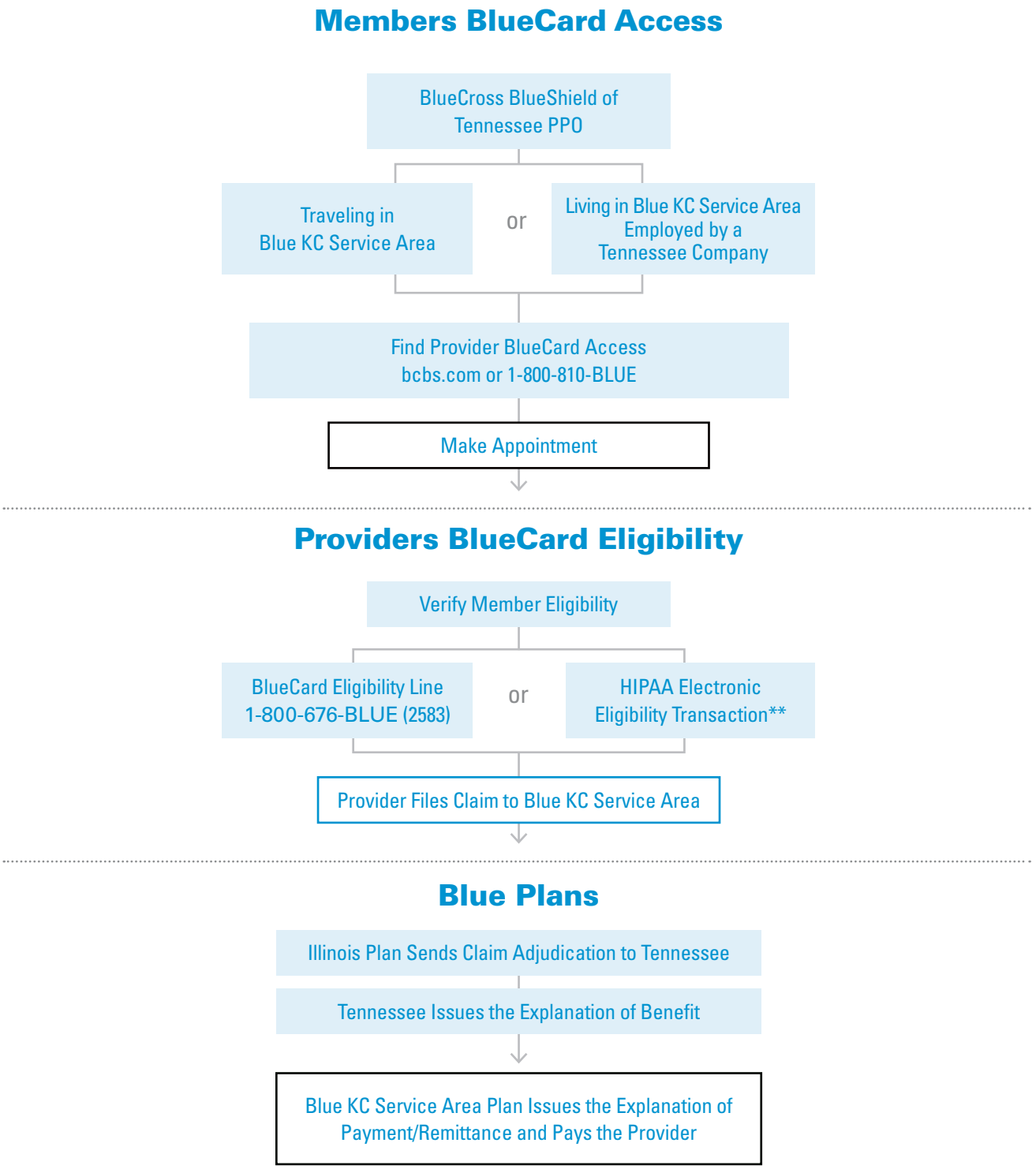
- Traditional indemnity insurance.
- BlueCard Worldwide claims.
- GeoBlue Expat claims.
- POS Point of Service.
- Medicaid:
  - Payment is limited to the member's plan's state Medicaid reimbursement rates. These cards will not have a suitcase logo.
  - Stand-alone State Children's Health Insurance plan (SCHIP) if administered as part of Medicaid.
    - Payment is limited to the member's plan's state Medicaid reimbursement rates. These member ID cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo.
- Standalone vision and standalone self-administered prescription drugs.
  - Programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

Definitions of the above products are available in the Glossary of Terms section of this manual.

Excluded Products

- Standalone dental.
- Vision delivered through an intermediary model (using a vendor).
- Self-administered prescription drugs delivered through an intermediary model (using a vendor).
- Medicaid and State Children's Health Insurance plan (SCHIP) that is part of the Medicaid program.
- Medicare Advantage - a separate program from BlueCard and delivered through its own centrally administered platform. See our Medicare for Other Blue Plans module for details.
- The Federal Employee Program (FEP), please follow Blue KC billing guidelines.

Program Example



**Members are responsible to find a PPO Provider to receive in-network benefits. The member can find information online at the BlueCard National Doctor and Hospital Finder available at* www.bcbs.com.

***HIPAA Electronic Eligibility Transaction is available only if the Provider has established electronic connections for such transactions with the local plan, Blue KC.*

Member Identification

Cards Symbols

When members of Blue plans arrive at a Provider's office or facility, be sure to ask them for their current Blue plan membership ID card. Both Blue KC and providers reserve the right to control the use of their respective names, symbols, trademarks and service marks. Parties cannot use each other's marks without prior written consent, which can be ceased if a withdrawal from consent or termination of agreement occurs.

PPO Logo 

BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase. This logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, providers will be reimbursed according to Blue KC Preferred-Care PPO Provider contract. Please note that EPO products may have limited out-of-area benefits. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

PPOB Logo 

The PPOB is for PPO members with access to the BlueCard PPO Basic network. The member has selected a PPO or EPO product from a Blue plan and the member has access to a new PPO network. Providers will be reimbursed for covered services in accordance with the Preferred-Care Blue PPO contract.

Blue High Performance Network 

BlueHPN is a collaboration across the U.S. with select healthcare providers that include primary care doctors, specialists and hospitals. Checking patient eligibility and benefits will be done the same way you do today for BlueCard PPO members by submitting a HIPAA 270 eligibility and benefit request transaction. We will indicate that the patient is part of the BlueHPN along with the appropriate member cost share on the eligibility and benefit response you typically receive from Blue KC. Local and out-of-area claims are to be submitted to Blue KC.

Empty Suitcase Logo 

The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional or HMO coverage, providers will be reimbursed according to Blue KC traditional Provider contract.

No Suitcase Logo

Some Blue plans ID cards don't have any suitcase logo on them. Government-determined reimbursement levels apply to these products:

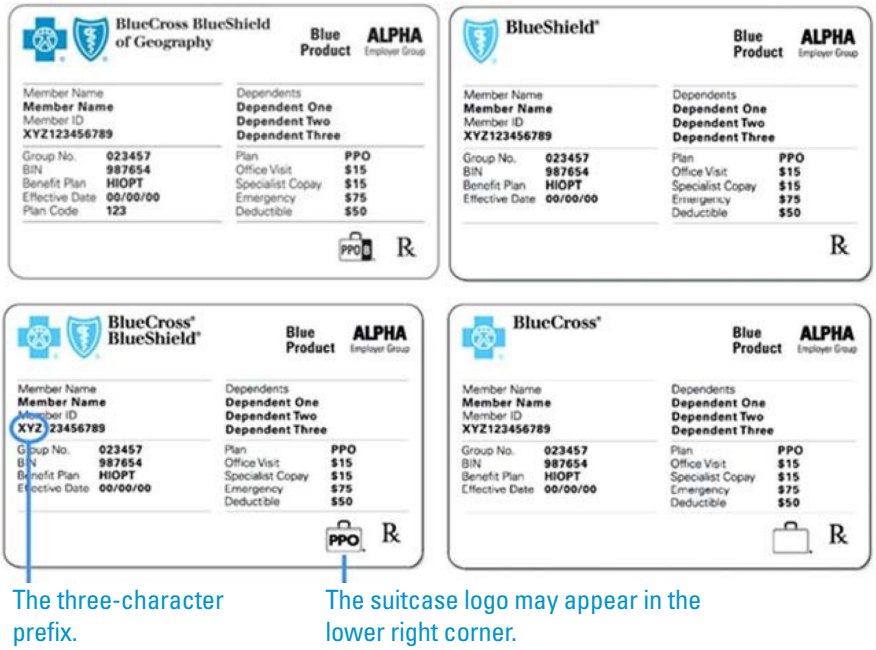
- Medicaid.
- State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid.
- Medicare Complementary and Supplemental products, also known as Medigap.

While Blue KC routes all of these claims for out-of-area members to the member's Blue plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's plan via the established electronic Medicare crossover process.

Provider Verification

Before any services are rendered, Provider must conduct a member verification under each benefit plan. Once verification is in place, Provider shall provide timely accessibility to members. Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure access to the most up-to-date information in the member's file. Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 1-800-676-BLUE (2583) to verify the ID number.

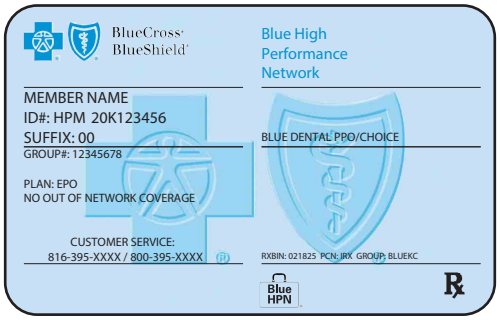
Sample ID Cards

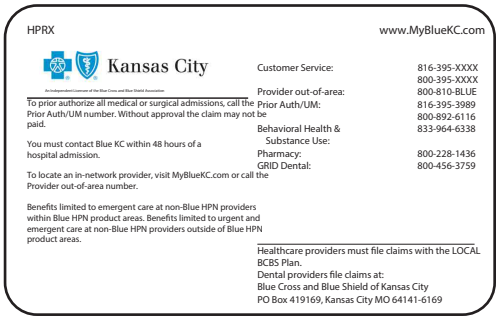


The three-character prefix.

The suitcase logo may appear in the lower right corner.

Blue High Performance Network





Prefix

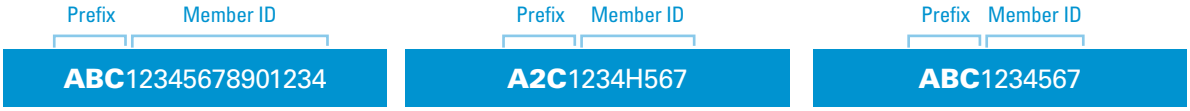
The three-character prefix at the beginning of the member's ID number is the key element used to identify and correctly route claims. Prefixes can be alpha, alphanumeric or numeric. The prefix identifies the Blue plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage and the electronic routing of specific HIPAA transactions to the appropriate Blue plan.

It is critical to capture all ID card data. If the information is not captured correctly, providers may experience a delay with claim processing.

A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means there may be cards with ID numbers between 6 and 14 numbers/letters following the prefix. Do not assume that the member's ID number is the social security number. All Blue plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.

- Please make copies of the front and back of the ID card and pass this key information to the billing staff.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- Do not make up prefixes.

Examples of ID numbers:



Accessing Blue KC Networks

Product	ID Card Logo	Blue KC Network
Standard PPO/EPO	PPO	Preferred-Care PPO
HMO/Traditional		Participating
*Alternative PPO	*Preferred-Care Blue* PPO	Preferred-Care Blue PPO
*Alternative PPO	*BlueSelect Plus* PPO	BlueSelect Plus PPO
*Alternative PPO	CENTRUS/ *BlueSelect Plus* PPO	BlueSelect Plus PPO
**PPO Basic	PPO B	Preferred-Care Blue PPO
***Blue High Performance Network EPO	*Blue High Performance Network* Blue HPN	Blue High Performance Network

** Alternative PPO ID cards will also have a PPO suitcase logo which is used when services are rendered outside the Blue KC service area.*

*** PPO Basic Exchange ID cards do not require PPOB logo when there is limited OOA benefits. A disclaimer of the limited OOA benefit will be on the card.*

**** Blue High Performance Network – EPO has no out of network (OON) benefits. OON services are limited to approved urgent and emergent services only.*

Preferred-Care Blue PPO and BlueSelect Plus PPO

Other Blue plans can use the PCB and BSP networks in the Kansas City area. The Preferred-Care Blue and BlueSelect Plus network logos is are on the ID cards along with the PPO suitcase logo. The members receiving services in the 32-county service area (see Blue KC Basics Module) must utilize the PCB or the BSP network to obtain a higher benefit level. The PPO suitcase applies to services rendered outside of our service area.

BlueCard HMO

The BlueCard program offers HMO members access to local Provider networks while traveling outside of their plan area. Blue HMO members are affiliated with other Blue plans who are seeking healthcare.

Identification

- These members have an **empty suitcase logo** on their ID card and have access to the participating network.
- There is a three-character prefix preceding the member's ID number on their card.

Eligibility

- As with the BlueCard PPO Program, the providers should call 1-800-676-BLUE (2583) to obtain HMO member eligibility, benefits and prior authorization information. All claims are submitted to Blue KC.
- The HMO benefit delivery as determined by the member's Blues plan may vary for non-emergent services. However, the BlueCard program supports Urgent and Follow-Up care as follows:
  - Urgent Care is available to HMO members who become ill or injured while traveling and cannot reasonably wait until returning home.
  - Follow-Up Care is a pre-arranged treatment for an illness or injury that originates before the member leaves home. The member's plan and PCP have approved certain services by where a written acknowledgement should be available from the member prior to receiving care outside the area.

Claim Submission

After providing services to a member, providers must submit a complete and accurate claim or encounter form in accordance with Blue KC's Policies and Procedures for claims, coding and pricing. All submissions must adhere to all applicable medical coding guidelines and policy standards.

- Send claims for these members the same way as any other traditional Blue KC plan by submitting them to Blue KC through the BlueCard program®.
- With the member's ID card in hand, call BlueCard Eligibility at 1-800-676-BLUE (2583).
  - QuickTip: for faster processing, use electronic capabilities.
- When prompted, provide the first three characters of the member's ID number (prefix).
- Once the member receives care, please do not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, coinsurance and non-covered services).
- Submit the member's claim with the member's complete ID number, which includes the prefix, to Blue Cross and Blue Shield of Kansas City. Blue KC will send a Remittance Advice.

International Members

Occasionally, you may see identification cards from members of the international licensees below. If in doubt, always check with Blue KC as the list of international licensees may change. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to Blue KC.

Identification

- ID cards from these licensees will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections.
- Virgin Islands, BlueCross and BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, Blue Cross Blue Shield of Costa Rica and GeoBlue are covered, but if in doubt, always check with Blue KC as the list of international licensees may change.

Canada Exception

The Canadian Association of Blue Cross plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member plans in the United States. Claims for Canadian Blue Cross plan members are not processed through the BlueCard program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members:

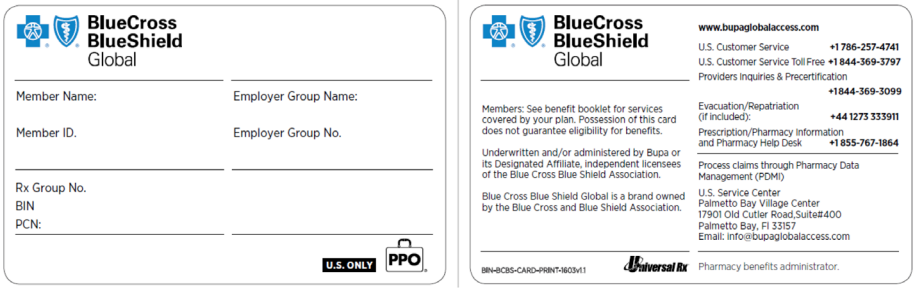
- Alberta Blue Cross
- Medavie Blue Cross
- Pacific Blue Cross
- Quebec Blue Cross
- Manitoba Blue Cross
- Saskatchewan Blue Cross
- Ontario Blue Cross

Source: http://www.bluecross.ca/en/contact.html

International Licensee

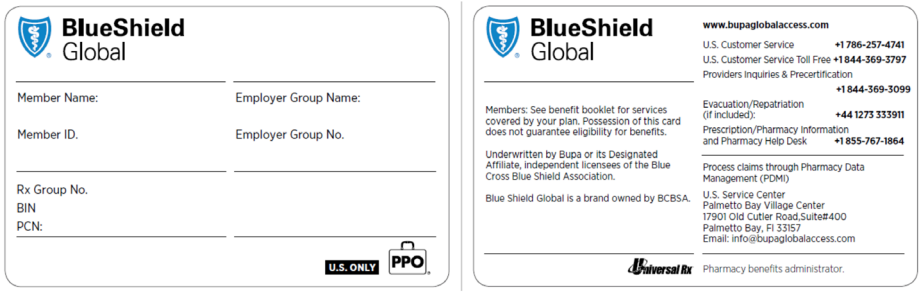
International GeoBlue Products

Blue Cross Blue Shield Global Core Portfolio



Shield-only ID Card

In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global Core logo.



BlueCard Business

For BlueCard business, the below scenarios apply for out-of-area network access for exchange members.

1. Exchange member with a PPO with a B suitcase logo
   - Providers are reimbursed at the Preferred Care Blue contract.
2. Exchange member with a PPO with a B suitcase logo and disclaimer language (no out-of-area benefits except urgent and emergent)
   - Providers are reimbursed at the Preferred Care Blue contract for urgent and emergent care only. All other services are non-covered due to the disclaimer language.
3. Exchange member with a PPO in a suitcase logo
   - Providers are reimbursed at the Preferred Care contract.
4. Exchange member with a PPO in a suitcase logo and disclaimer language (no out-of-area benefits except urgent and emergent)
   - Providers are reimbursed at the Preferred Care contract for urgent and emergent care only. All other services are non-covered due to the disclaimer language.

5. Exchange member with a blank suitcase logo is enrolled in one of the following products: Traditional, HMO or POS.
   - Providers will be reimbursed according to BlueCard Traditional contract.
6. Exchange member with no suitcase
   - This scenario should only occur when there are zero out-of-area benefits. However, there are plans that have a formal exception in place to eliminate the logo for exchange members when there is only out-of-area urgent and emergent coverage.
     – If the member has access to BlueCard PPO Basic then Provider will be reimbursed at the PCB contract.

     NOTE: There is no ID card indicator to identify exchange members.

Consumer Directed Healthcare

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, Provider and network information and financial incentives.

Healthcare Debit Cards

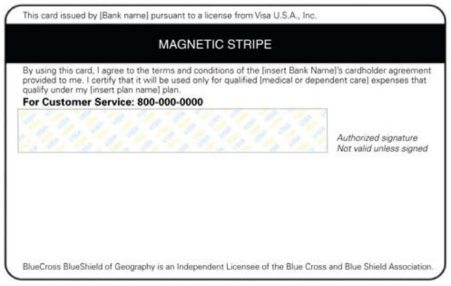
Members who have CDHC plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan. Some cards are "stand-alone" debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card.

The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e. copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

These debit cards simplify the administration process and can potentially help:

- Reduce bad debt and paperwork for billing statements.
- Minimize bookkeeping and patient account functions for handling cash and checks.
- Avoid unnecessary claim payment delays.

Stand-Alone Healthcare Debit Card



Combined Healthcare Debit Card and Member ID Card

Identification

- In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.
- Using the member's current member ID number, including prefix, carefully determine the member's financial responsibility before processing payment.
- All services, regardless of whether the Provider has collected the member responsibility at the time of service, must be billed to Blue KC for proper benefit determination and updates to the member's claim history.
- Please do not use the card to process full payment up front.

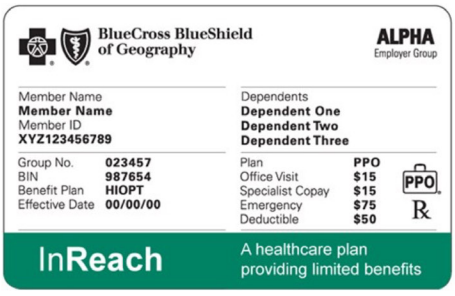
If providers have any questions or for providers to check eligibility and benefits, please contact 1-800-676-BLUE (2583).

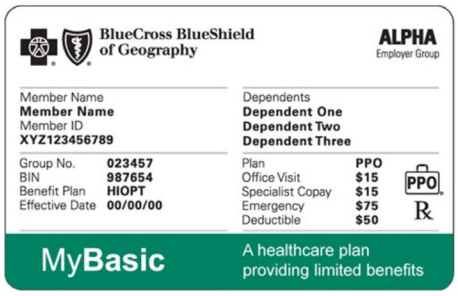
For questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.

Limited Benefits Products

Members with Blue limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as InReach or MyBasic.
- A green stripe at the bottom of the card.
- A statement either on the front or the back of the ID card stating this is a limited benefits product.
- A black cross and/or shield to help differentiate it from other ID cards.





Eligibility

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend verifying patient's benefits and eligibility. Providers can receive patient's accumulated benefits as well as the remaining benefits left for the member. Please contact Blue KC with any questions regarding a Blue plan's limited benefits ID card/product:

There are three ways to verify:

- Electronically, by submitting **HIPAA 270** eligibility inquiry to Blue KC at Providers.BlueKC.com.
- Electronic Data Interchange (EDI) transaction.
- Call 1-800-676-BLUE (2583) eligibility line for out-of-area members.

In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, providers receive the member's accumulated benefits as well as the remaining benefits. If the cost of service extends beyond the member's benefit coverage limit, please inform patients of any additional liability he/she might have. If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

Exhausted Benefits

- Annual benefit limits should be handled in the same manner as any other limits on the medical coverage.
- Any services beyond the covered amounts or the number of treatments are the member's liability.
- We recommend informing the patient of any potential liability they might have as soon as possible.

Reference Based Benefits

With healthcare costs increasing, employers are placing a greater emphasis on employee accountability by encouraging members to take a more active role while making healthcare decisions.

The reference costs are established for an episode of care based on claims data received by Blue KC from surrounding providers. Reference Based Benefits are a new benefit feature where the plan will pay up to a pre-determined amount for specific procedures called a "Reference Cost." If the allowed amount exceeds the reference cost, that excess amount becomes the members' responsibility.

For more information on how Reference Based Benefits will apply costs to the professional and facility charges, please submit an electronic benefits and eligibility inquiry to the members' local Blue plan. Contact the Blue Eligibility number, 1-800-676-BLUE (2583), with any questions. For electronic Provider access, see section 3.8.

Cost Sharing

The goal of Reference Based Benefits is to have members engage in their health choices by giving them an incentive to shop for cost-effective providers and facilities. They limit allowables for certain (or specific) benefits to a dollar amount that incents members to actively shop for healthcare for those services.

Due to the possibility of increased member cost sharing, Reference Based Benefits will incent members to use plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost effective providers and/or facilities that charge at or below the reference cost ceiling.

Reference Based Benefits will not modify the current contracting amount agreed on between the Provider and Blue KC. Providers can expect to receive their contract rate on all procedures.

When Reference Based Benefits are applied and the cost of the services rendered is less than the reference cost ceiling, then Blue KC will pay eligible benefits and the member continues to pay their standard cost sharing amounts in the forms of co-insurance, co-pay or deductible as usual.

If the cost of the services rendered exceeds the reference cost ceiling, then Blue KC will pay benefits up to that reference cost ceiling, while the member continues to pay their standard cost sharing amounts in the forms of co-insurance, co-pay or deductible; as well as any amount above the reference cost ceiling up to the contractual amount.

Members

- Members are responsible for any expenses above a calculated "reference cost" ceiling for a single episode of service.
- Members use consumer transparency tools to determine if a Provider will deliver the service for less than the reference cost.
- Since members are subject to any charges above the reference cost is up to the contractual amount for particular services, members may ask providers to estimate how much a service will cost.
- Direct members to view their Blue plans transparency tools to learn more about the cost established for an episode of care.

Identification

- When a response is received from a benefits and eligibility inquiry, providers will be notified if a member is covered under Reference Based Benefits.
- Please call the Blue Eligibility number, 1-800-676-BLUE (2583), to verify if a member is covered under Reference Based Benefits.

Eligibility

- Reference Based Benefits are not applicable to any service that is urgent or emergent.
- Reference Based Benefits are permitted under the ACA.

Claims

- While there are no additional steps needed, providers may want to verify the reference cost maximum prior to performing a procedure covered under Reference Based Benefits.
- Providers can check if Reference Based Benefits apply to professional and facility charges for the member, by submitting an electronic benefits and eligibility inquiry to the local Blue plan. Alternatively, providers can contact the member's plan by calling the Blue Eligibility number, 1-800-676-BLUE (2583).
- Providers should continue to submit claims as usual to Blue KC.
- When payment for services are received, the claim will pay per the member's benefits with any amount over the reference cost being applied to the Benefit Maximum.

Example 1

If a member has a reference cost of $500 for an MRI of the spine and the allowable amount is $700, then Blue KC will pay up to the $500 for the procedure and the member is responsible for the $200.

Example 2

If a member has a reference cost ceiling of $600 for a CT scan of the head/brain and allowable amount is $400, then Blue KC will pay up to the $400 for the procedure.

Verification Options

Coverage and Eligibility Check

Electronically

- Submit a HIPAA 270 transaction (eligibility) to Blue KC.
- Monday through Saturday, providers can receive real-time responses to eligibility requests 6:00 a.m. through Midnight, CST.

By Phone

- Call BlueCard Eligibility 1-800-676-BLUE (2583)
  - For eligibility, benefit and prior authorization inquiries only, the eligibility phone should not be used for claim status. See the Claims Billing and Remittance module for details.
  - English and Spanish speaking phone operators are available.
- Blue plans are located throughout the country and may operate on a different time schedule. If calling outside of that plan's regular business hours, providers may be transferred to a voice response system linked to the customer enrollment and benefits.

Electronic Health ID Cards

Some local BCBS plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process. Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the Provider's system.

- A Blue electronic health ID card has a magnetic stripe on the back of the ID card. The subscriber's/member's electronic data (name, ID, date of birth and Plan ID) is embedded on the third track of its three-track magnetic stripe.
  - Providers will need a track 3 card reader to read the data.
  - A majority of card readers in Provider offices only read tracks 1 and 2 of the magnetic stripe (tracks 1 and 2 are proprietary to the financial industry).
- The Plan ID data element identifies the health plan that issued the ID card and helps providers facilitate health transactions among various payers in the Marketplace.

Electronic Health ID Card

Utilization Review

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

- Prior Authorization - prior review of services including all inpatient stays. services are medically necessary services and supplies covered under the Provider Agreement, the member's Benefit Plan
- Quality Improvement - process that oversees 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 as well as state and federal law. This applies for any Benefit Plan even ones that aren't administered by Blue KC.

Prior Authorization

Remind patients that they are responsible for obtaining prior authorization for out-patient services.

Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see page 21 of this module, Provider Financial Responsibility). Members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception). When obtaining prior authorization, please provide as much information as possible, to minimize potential claims issues.

Modifications

Providers are encouraged to follow-up immediately with a member's Blue plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

Timing

- 48 hours to notify the member's plan of change in pre-service review.
- 72 hours for emergency/urgent pre-service review notification.

Check Blue KC Members

General information on prior authorization information can be found at Providers.BlueKC.com under Medical Policies.

Check Other Blue Plan Members

The member's Blue plan may contact providers directly regarding clinical information and medical records prior to treatment or for Concurrent Review or disease management for a specific member.

Electronically

- Submit an electronic HIPAA 278 transaction (prior authorization) to Blue KC.

Phone

When prior authorization for a specific member is handled separately from eligibility verifications, calls will be routed directly to the area that handles prior authorization.

- Call BlueCard Eligibility 1-800-676-BLUE (2583) and ask to be transferred to the utilization review area.
  - Choose from four options depending on the type of service: medical/surgical, behavioral health, diagnostic imaging/radiology or durable/Home Medical Equipment (D/HME).
  - If inquiring about both, eligibility and prior authorization, the eligibility inquiry will be addressed first.

Prior Authorization Review

Check whether prior authorization is required by the home plan:

- Sending a service-specific request through BlueExchange.
- Accessing the home plan's prior authorization requirements via Medical Policies at Providers.BlueKC.com.

Electronic Provider Access

Electronic Provider Access (EPA) enables providers to use their local Blue plan Provider portal to gain access to an out-of-area member's *home plan Provider portal*, through a secure routing mechanism. The out-of-area Provider has the same access to electronic pre-service review capabilities as the home plan's local providers.

The availability of EPA varies depending on the capabilities of each home plan. Some home plans have electronic pre-service review for many services, while others do not.

Check Blue KC Members

- The first step is to go to Providers.BlueKC.com and login.
- Next enter the prefix (first three characters that precede the member ID) from the member's ID card.

Check Other Blue Plan Members

- The first step is to go to Providers.BlueKC.com and login.
- Next, enter the prefix (first three characters that precede the member ID) from the member's ID card.

- The portal will automatically forward to the home plan EPA landing page and give a notice that the Provider Portal is no longer active.
  - This landing page allows providers to connect to the available electronic pre-service review processes.
  - Includes instructions for conducting pre-service review for services where the electronic function is not available.

Because the screens and functionality of home plan pre-service review processes vary widely, home plans may include instructional documents or e-learning tools on the home plan landing page and provide instruction on how to conduct an electronic pre-service review. The home plan landing page looks similar across home plans, but will be customized to the particular home plan based on the electronic pre-service review services they offer.

Provider Financial Responsibility

The BlueCard member must be held harmless and cannot be balance-billed if prior authorization review has not occurred. Services that are denied as not medically necessary remain the member's liability.

Blue KC participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services.

Failure to contact the member's Blue plan for pre-service review or for a change or modification of the pre-service review will result in claims being denied and/or sanctioned for inpatient facility services.

Timing Responsibilities

- Notify the member's Blue plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Check Requirements for Members

Electronically

- Pre-service review contact information for a member's Blue plan is provided on the member's ID card.
- Using the Electronic Provider Access (EPA) tool available at Providers.BlueKC.com. The availability of EPA will vary depending on the capabilities of each member's Blue plan.
- Submitting an ANSI 278 electronic transaction to Blue KC.

Phone

- Call 1-800-676-BLUE (2583).

Updating Provider Information

Providers authorize Blue KC to use names and other relevant, current information in the network Provider Directory and other marketing material. Providers must inform Blue KC of any changes 45 days prior to change taking effect, so we are timely in making updates to be compliant with federal and state requirements. If Blue KC is fined or penalized for any Directory inaccuracies, Provider shall provide reimbursement to Blue KC.

Maintaining accurate Provider information is critically important to ensure that consumers have timely access to care. Updated information helps us maintain accurate Provider directories and also ensures that providers are more easily accessible to members. Additionally, plans are required by Centers for Medicare & Medicaid Services (CMS) to include accurate information in Provider directories for certain key Provider data elements and accuracy of directories are routinely reviewed/audited by CMS.

Since it is the responsibility of each Provider to inform plans when there are changes, providers are reminded to report any changes to their demographic information or other key pieces of information, such as a change in their ability to accept new patients, street address, phone number or any other change that affects patient access to care. For a plan to remain compliant with federal and state requirements, changes must be communicated back to Providers within 30 days so that members have access to the most current information in the Provider Directory.

Key Data Elements

The data elements required by CMS and crucial for member access to care are as follows:

- Physician name.
- Location (i.e. address, suite, city/state, zip code).
- Phone number.
- Accepting new patient status.
- Hospital affiliations.
- Medical group affiliations.

Plans are also encouraged to include accurate information for the following Provider data elements:

- Physician gender.
- Languages spoken.
- Office hours.
- Specialties.
- Physical disabilities accommodations (e.g., wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, other accessible equipment).
- Indian health service status.
- Licensing information (i.e. medical license number, license state, national Provider identifier NPI)
- Provider credentials (i.e. board certification, place of residency, internship, medical school, year of graduation). Providers must hold all accreditations required by local, state or federal laws to conduct business and perform obligations within the Provider Agreement. Providers shall cooperate and provide all credentialing requirements in a timely manner. Any licensing investigation against a Provider or affiliated Provider must be reported to Blue KC. If Blue KC delegates credentialing to the Provider, the above information shall be superseded.
- Email and website address.
- Hospital emergency department (if applicable).

How to Update Provider Information

Providers should routinely check current practice information by going to Providers.BlueKC.com. If the information is not correct and updates are needed, please provide the correct information as soon as possible.

For more information, contact a **Provider Representative/Account Executive**.

Providers should always submit claims to Blue KC.

Claim Filing

After providing services to a member, providers must submit a complete and accurate claim or encounter form in accordance with Blue KC's Policies and Procedures for claims, coding, and pricing. All submissions must adhere to all applicable medical coding guidelines and policy standards.

After the member of another Blue plan receives healthcare services, file the claim with Blue KC. We will work with the member's plan to process the claim and the member's plan will send an explanation of benefit or EOB to the member. We will send an explanation of payment or the remittance advice and issue the payment under the terms of our contract and based on the members benefits and coverage.

BlueCard Example

1	2	3	4	5	6	7
Member of another Blue plan receives services from the Provider.	Provider submits claim to the local Blue plan.	Local Blue plan recognizes BlueCard member and transmits standard claim format to the member's Blue plan.	Member's Blue plan adjudicates claim according to the member's benefit plan.	Member's Blue plan issues an EOB to the member.	Member's Blue plan transmits claim payment disposition to the local Blue plan.	Local Blue plan pays the Provider.

Patient Check-In and Claim Filing Steps

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back).
  - Having the current card enables providers to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at Providers.BlueKC.com or by calling 1-800-676-BLUE (2583). Be sure to provide the member's prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment up front.
- Claims should be submitted electronically in a HIPPA standard or otherwise on a UB-04 or CMS 1500 standard form. Providers should use appropriate CPT®, HCPCS, NCCI and revenue codes, and avoid sending duplicate bills to Blue KC sooner than 30 days after original submission.

- Indicate any payment that was collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=F5 patient paid amount; on the CMS1500 locator 29 amount paid; on UB92 locator 54 prior payment; on UB04 locator 53 prior payment.)
- Submit all Blue claims to Blue KC. Be sure to include the member's complete ID number. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member ID numbers cannot be processed.
- In cases where there is more than one payer and a Blue plan is a primary payer, submit Other Party Liability (OPL) information with the Blue claim. Upon receipt, Blue KC will electronically route the claim to the member's Blue plan. The member's plan then processes the claim and approves payment. Blue KC will reimburse for the services.
- Do not send duplicate claims. Sending another claim or having a billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claims status by contacting Blue KC or submitting an electronic HIPAA 276 transaction (claim status request) to Blue KC.
- Claims must be submitted no later than 180 days after date of service. If not submitted within this period, claims will not be honored and the Provider will not bill members for services associated with such claims.

BlueCard Program QuickTips

The BlueCard program lets providers file all claims for members from other Blue plans.

- Make a copy of the front and back of the member's ID card.
- Look for the three-character prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 1-800-676-BLUE (2583) to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) to the local plan.
- Submit the claim to Blue KC electronically via Administrative Services of Kansas (ASK) or if necessary, on paper. Always include the patient's complete ID number, which includes the three-character prefix. See Claims document for details.

For claims inquiries, check Providers.BlueKC.com or call BlueCard Provider Hotline. See Contact Resource Directory for details.

Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA) of 2010 provides for the establishment of Health Insurance Marketplaces (i.e., Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage.

The intent of the Marketplace is to:

- Create a competitive health insurance marketplace by offering consumers a choice of health insurance plans.
- Establish common rules regarding insurance plan offerings and pricing.
- Provide information to help consumers better understand the options available to them.
- Allow individual and small businesses to have the purchasing power comparable to that of large businesses.

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses and improving consumer satisfaction.

All states have health insurance marketplaces where consumers can compare health insurance product features, coverage and costs. Some states have set up their own, state-based Marketplace. In other states, the U.S. Department of Health and Human Services (HHS) has established a federally facilitated Marketplace, federally-supported Marketplace or a state-partnership Marketplace in the state.

Blue plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation and other operations to ensure that consumers can seamlessly enroll in individual and small business health insurance products.

Exchange Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three-month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue KC indicating that the member is in the grace period.

Post-service Notification Letter to Provider

- Unique ID number (claim includes member information).
- Name of the Qualified Health Plan (QHP) and affiliated issuer (home plan name).

Three-month Grace Period for Individuals

Under the Patient Protection and Affordable Care Act (PPACA), there is a three-month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies.

Please contact Blue KC Monday through Friday, at 1-800-320-9550 with questions regarding a claim.

Health Insurance Marketplaces Claims

Products on the marketplaces should continue to follow current practices with Blue KC for claims processing:

1. Eligibility and Benefits
2. Care Management
   - Pre-Service Review
   - Medical Policy
3. Claim Pricing and Processing
   - Contracting
   - Claim Filing
   - Pricing
   - Claim Processing
4. Medical Records
5. Payment
6. Customer Service

During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period and individuals affected under the policy and possibly under care of the Provider.

31-day Grace Period for Employers

Federally facilitated SHOP requires a 31 day grace period for employers to make their full monthly payment, unless a state's regulation requires a longer period. Similar to the individual grace period, upon receipt of a claim filed during the SHOP grace period, Blue plans may pay the claim or may pend (is this correct?) the claim, then adjudicate the claim to pay or deny once the grace period ends or the employer pays the premium.

Notification Example

> *Please be advised that a premium due has not been received for [insert name of member] and that the member and any eligible dependents, are and at the time care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium and will be denied if the premium is not paid by the end of the grace period.*

Consequences

If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

Please contact the BlueCard Provider Hotline (See Contact Resource Directory) with any questions about where to file a claim.

Ancillary Claims

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers.

- Independent Clinical Laboratory (Lab): The plan in whose state the specimen was drawn based on the location of the referring Provider.
- Durable/Home Medical Equipment and Supplies (D/HME): The plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy: The plan in whose state the Ordering Physician is located.

The ancillary claim filing rules apply regardless of the Provider's contracting status with the Blue plan where the claim is filed.

Providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of

Provider Type	How to File (required fields)	Where to File	Example
Independent Clinical Laboratory (any type of non-hospital- based laboratory) Types of service include, but are not limited to: blood, urine, samples, analysis, etc.	**Referring Provider**: • Field 17B on CMS 1500 Health Insurance Claim Form or • Loop 2310A (claim level) on the 837 Professional Electronic.	File the claim to the plan in whose state the specimen was drawn. Where the specimen was drawn will be determined by which state the referring Provider is located.	Blood is drawn* in a lab or office setting located in the Blue KC servicing area. Blood analysis is done in Nebraska (BCBSNE). File to: Blue KC. *Claims for the analysis of a lab must be filed to the plan in whose state the specimen was drawn.
Durable/Home Medical Equipment and Supplies (D/HME) Types of service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc.	**Patient's Address:** • Field 5 on CMS 1500 Health Insurance Claim Form or • Loop 2010CA on the 837 Professional Electronic Submission. **Ordering Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form or • Loop 2420E (line level) on the 837 Professional Electronic Submission. **Place of Service:** • Field 24B on the CMS 1500 Health Insurance Claim Form or • Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. **Service Facility Location Information:** • Field 32 on CMS 1500 Health Insurance Form or • Loop 2310C (claim level) on the 837 Professional Electronic Submission.	File the claim to the plan in whose state the equipment was shipped to or purchased in a retail store.	1. Wheelchair is purchased at a retail store in Blue KC. File to: Blue KC 2. Wheelchair is purchased on the internet from an online retail supplier in BCBSNE and shipped to Blue KC. File to: Blue KC 3. Wheelchair is purchased at a retail store in Blue KC and shipped to BCBSNE. File to: BCBSNE
Specialty Pharmacy Types of service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member's plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.	**Referring Provider:** • Field 17B on CMS 1500 Health Insurance Claim Form or • Loop 2310A (claim level) on the 837 Professional Electronic Submission.	File the claim to the plan whose state the ordering Provider is located.	Patient is seen by a Provider in Blue KC service area who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in BCBSNE where the member lives for 6 months of the year. File to: Blue KC

the member ID card or call 1-800-676-BLUE (2583), prior to providing any ancillary service.

Providers who use outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should use in-network participating ancillary providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained on the Blue KC website (see Contact Resource Directory).

Responsibility

Members are financially liable for ancillary services not covered under their benefit plan. It is the Provider's responsibility to request payment directly from the member for non-covered services.

Air Ambulance Claims

Claims for air ambulance services must be filed to the Blue plan in whose service area the point of pickup ZIP code is located. The air ambulance claims filing rules apply regardless of the Provider's contracting status with the Blue plan where the claim is filed.

If provider's contract with more than one plan in a state for the same product type (i.e., PPO or Traditional), that

How to File (required fields)	Where to File	Example

• Point of pickup zip code:
• Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup
  • For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.
• Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.
  • Form Locators (FL) 39-41
  • Code: A0 (Special ZIP code reporting) or its successor code specified by the National Uniform Billing Committee.
  • Value: five-digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.
  • For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional.
	File the claim to the plan in whose service area the point of pickup ZIP code is located*.
	
	*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.
		• The point of pick up ZIP code is in plan A service area.
		• The claim must be filed to plan A, based on the point of pickup Zip code.

provider may file the claim with either plan.

- Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1-800-676-BLUE.
- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Providers.BlueKC.com.
- Members are financially liable for air ambulance services not covered under their benefit plan. It is the Provider's responsibility to request payment directly from the member for non-covered services.

International Members

The claim submission process for international Blue plan members is the same as for domestic Blue members. Providers should submit the claim directly to Blue KC. Code claims the same as Blue KC claims.

See section for servicing international members and the details regarding members of the Canadian Blue Cross plans.

Contiguous Counties in the State of Kansas

Blue KC has elected to contract with providers in the following contiguous Kansas counties: Atchison, Douglas, Franklin, Leavenworth and Miami. Contracted providers will file claims for Blue KC members directly to Blue KC (rather than as BlueCard claims to Blue Cross and Blue Shield of Kansas). All other Blue member claims should be filed to Blue Cross and Blue Shield of Kansas.

Medical Records

Providers must prepare, maintain and protect all medical health record in accordance to the Provider Agreement. These records shall be preserved for the longer of 6 years after termination of agreement or following the

completion of any audit.

Blue KC is authorized to access, inspect, audit and review all claims and records obtained by participating providers. For detailed information on these Blue KC Policies and Procedures, please refer to the Provider Agreement.

Failure to provide or release records, information or data as required under the Provider Agreement constitutes a material breach of the agreement and, in Blue KC's sole discretion, may result in termination of this Agreement. Blue KC reserves the right to recoup payments made to the Provider. The Provider is not entitled to consequential damages if a termination is in result of failure to provide or release records. Provider is entitled to remuneration according to the terms of the Provider Agreement.

Electronic Medical Records

Blue plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or mis-routed records.

Requests for Out-of-Area Members

Prior Authorization Process

If a Provider receives request for medical records from other Blue Plans prior to rendering services, as part of the prior authorization process, they will be instructed to submit the records directly to the member's plan that requested them. This is the only circumstance where a Provider would not submit them to Blue KC.

Claim Review and Adjudication

These requests will come from Blue KC in the form of a letter, fax, email or electronic communication requesting specific medical records and including instructions for submission.

Remittance Advice

1. An initial communication, generally in the form of a letter, should be received by a Provider's office requesting the needed information.
   - A remittance may be received indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records submitted might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If medical records were previously submitted, but received a remittance advice indicating records were still needed, please contact BlueCard Provider Hotline (see Contact Resource Directory) to ensure the original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
2. If a Provider received only a remittance advice indicating records are needed, but did not receive a medical records request letter, contact Blue KC to determine if the records are needed.
3. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Adjustments

Contact Blue KC if an adjustment is required. We will work with the member's Blue plan for adjustments. A Provider's workflow should not be different.

Provider Assistance Increases Efficiency

1. If the records are requested following submission of the claim, forward all requested medical records to Blue KC.
2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address used to submit claims.
3. Include the cover letter that was received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue KC.
4. Please submit the information to Blue KC as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Appeals

Appeals for all claims are handled through Blue KC. If the initial denial is upheld following the submission of a claim inquiry form, a formal appeal can be submitted by sending a second claim inquiry form with a formal appeal letter attached and any additional medical records or documentation. Blue KC will coordinate the appeal process with the member's Blue plan, if needed.

Providers may request reconsideration of adjudicated claim. Blue KC may adjust an adjudicated claim if it is determined that the claim was incorrectly paid or denied.

Providers must give Blue KC written notice of a request for reconsideration within 90 days of the disallowance, payment, or other notice of adjudication. If the Provider fails to request reimbursement in a timely manner, the Provider can't bill or seek reimbursement from a member that was denied.

These adjustments are possible even after the 90 day period:

1. Claims for services rendered to a member under the Federal Employee Health Benefits Program (FEP).
2. Claims involving subrogation for self-funded groups not governed by state law.
3. Claims involving Coordination of Benefits with Medicare or another private payor.
4. Claims involving fraud, alleged fraud, and/or misrepresentation. Fraud means a claim which is based on a misstatement or omission of material fact by a member or Provider, resulting in incorrect adjudication of a claim.
5. Claims where a longer period of time is required by applicable state or federal law.
6. Claims where Blue KC or Provider is ordered to adjust a claim because of a decision in a health care appeal or other administrative/judicial proceeding.

7. Claims under a worker's compensation policy.

Coordination of Benefits (COB) Claims

Coordination of Benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Blue KC and Provider shall coordinate benefits with the non-duplication provisions of the member's Benefit Plan and applicable law. Third-party payment collection must also follow identification procedures for proper Coordination of Benefits.

The providers must ask members for duplicate or COB coverage information, and shall notify Blue KC of any potential or actual duplicate COB coverage through Blue KC's claims filing practices.

Any payment incorrectly collected for services of a third party responsibility should be returned to Blue KC by Provider. Provider shall not withhold services nor require member to pay for services pending determination of primary responsibility.

When another payor is involved, the total of all payments will not exceed the amount specified in the member's Benefit Plan. Blue KC shall never pay more than the Blue KC allowed amount. If not other payor is involved, the Provider shall write off any balance as if Blue KC was the sole source of payment.

Blue KC's liability for members with additional health insurance coverage will be governed by the member's Benefit Plan.

See the Contact Resource Directory for information on reaching BlueCard Customer Service or contact the **Provider Representatives/Account Executives** assigned to the Provider.

Member with More than One Health Plan

- When Blue KC or any other Blue plan is the primary payer, submit the other carrier's name and address with the claim to Blue KC. If this information isn't included with the COB information, the member's Blue plan will have to investigate the claim. This investigation could delay Provider payment or result in a post-payment adjustment, which will increase administrative burden.
- Other non-Blue health plan is primary and Blue KC or any other Blue Plan is secondary, submit the claim to Blue KC only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If this information isn't included with the COB information, the member's Blue plan will have to investigate the claim. This investigation could delay Provider payment or result in a post-payment adjustment, which will increase administrative burden. We can accept secondary claims electronically.
- Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Blue KC remittance advice as "patient liability" might be different from the actual amount the patient owes to the Provider (due to the combination of the primary insurer payment and the Provider's negotiated amount with Blue KC).

- For professional claims, if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, either "YES" or "NO" be checked. Leaving the box unmarked can cause the member's plan to stop the claim to investigate for COB.

Claim Payment

- If the payment for a claim hasn't been received, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple Explanations of Benefits (EOBs).
- Payments should be made within 30 days after the claim is made final. Payor shall pay Provider for services in accordance with the payment rates or notify Provider of delay. Under provisions of RSMo 376.383, claims not paid within 45 days shall be subject to interest charges. Blue KC will notify Provider of incomplete claims in a timely manner.
- Claim processing times at various Blue plans vary.
- If payment or a response regarding a payment has not been received, please call Blue KC's BlueCard **Provider Hotline** (see Contact Resource Directory) or check Providers.BlueKC.com to check the status of the claim.
- In some cases, a member's Blue plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from the Provider, Blue KC may either ask for the information or give the member's plan permission to contact the Provider directly.

Claim Inquiries

Blue KC is a Provider's single point of contact for all claim inquiries.

Claim status inquires can be done by:

- Electronically—send a HIPAA transaction 276 (claim status inquiry) to Blue KC.
- Phone—call **Provider Hotline** (see Contact Resource Directory).

Calls from Members and Others with Claim Questions

If other Blue plan members contact the Provider, advise them to contact their Blue plan and refer them to their ID card for a customer service number.

Regarding claims issues, the member's plan should not contact the Provider directly, but if the member does reach out asks their Provider to submit the claim, please refer them to Blue KC.

Frequently Asked Questions

What Is the BlueCard program?

BlueCard is a national program that enables members of one Blue plan to obtain healthcare service benefits while traveling or living in another Blue plan's service area. The program links participating healthcare providers with the independent Blue plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets providers conveniently submit claims for patients from other Blue plans, domestic and international, to a local Blue plan.

A Provider's local Blue plan is their sole contact for claims payment, adjustments and issue resolution.

What products are included in the BlueCard program?

- Traditional (indemnity insurance).
- PPO (Preferred Provider Organization).
- EPO (Exclusive Provider Organization).
- BlueHPN℠ (Blue High Performance Network).
- POS (Point of Service).
- HMO (Health Maintenance Organization).
- Medigap.
- Medicaid: payment is limited to the member's plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo.
- SCHIP (State Children's Health Insurance plan) if administered as part of Medicaid: payment is limited to the member's plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo.
- Standalone SCHIP programs will have a suitcase logo.
- Standalone vision.
- Standalone prescription drugs.

Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed thru BlueCard when products like the list above are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

What products are excluded from the BlueCard program?

- Stand-alone dental.
- Medicare Advantage
- The Federal Employee Program (FEP) Please follow Blue KC billing guidelines.

What is the BlueCard Traditional Program?

It is a national program that offers members traveling or living outside of their Blue plan's area traditional or indemnity level of benefits when they obtain services from a Provider or hospital outside of their Blue plan's service area.

What is the BlueCard PPO Program?

It is a national program that offers members traveling or living outside of their Blue plan's area the PPO level of benefits when they obtain services from a Provider or hospital designated as a BlueCard PPO Provider.

Are HMO patients serviced through the BlueCard program?

Yes, occasionally, Blue HMO members affiliated with other Blue plans will seek healthcare. Handle claims for these members the same way as other Blue KC members and Blue traditional, PPO and POS patients from other Blue plans by submitting them to the Blue KC. Please be sure to always check the member's benefits. Some HMO members only have access to urgent/emergent care when they are outside of their home plan's servicing area.

How do I identify members?

When members from Blue plans arrive, be sure to ask them for their current Blue plan membership ID card. The main identifier for out-of-area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members.
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network.
- Blank suitcase logo.

What is a prefix?

The three-character prefix at the beginning of the member's ID number is the key element used to identify and correctly route claims. The prefix identifies the Blue plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

What do I do if a member has an ID card without a prefix?

Some members may carry outdated ID cards that may not have a prefix. Please request a current ID card from the member.

How do I identify international members?

There are ID cards from members residing abroad or foreign Blue plan members. These ID cards will contain three-character prefixes. Please treat these members the same as domestic Blue plan members.

What do I do if a member does not have an ID card?

Call the BlueCard Provider Hotline (see Contact Resource Directory).

How do I verify membership and coverage?

For other Blue plan members, contact Blue KC electronically or BlueCard Eligibility by phone to verify the patient's eligibility and coverage:

- Electronic—Submit a HIPAA 270 transaction (eligibility) to Blue KC.
- Phone—Call BlueCard Eligibility (see Contact Resource Directory).

How do I obtain utilization review?

Remind patients that they are responsible for obtaining prior authorization/authorization for outpatient services from their Blue plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility). See Utilization Review section.

Contact the member's plan on the member's behalf.

- Phone—Call the utilization management/prior authorization number on the back of the member's card. If the utilization management number is not listed on the back of the member's card, call BlueCard Eligibility 1-800-676-BLUE (2583) and ask to be transferred to the utilization review area.
- Electronic—Submit a HIPAA 278 transaction (prior authorization) to Blue KC.

See Electronic Provider Access section.

Where and how do I submit claims?

After providing services to a member, Providers submit a complete and accurate claim or encounter form in accordance with Blue KC's Policies and Procedures for claims, coding, and pricing. All submissions must adhere to all applicable medical coding guidelines and policy standards.

Claims should be submitted electronically in a HIPPA standard or otherwise on a UB-04 or CMS 1500 standard form. Providers should use appropriate CPT®, HCPCS, NCCI and revenue codes, and avoid sending duplicate bills to Blue KC sooner than 30 days after original submission. If bill is duplicated, the Provider may be required to repay amounts or it may be deducted from subsequent amounts due.

Providers should always submit claims to Blue KC electronically via Administrative Services of Kansas (ASK) or if necessary, on paper. Be sure to include the member's complete ID number when submitting the claim. The complete ID number includes the three-character prefix. Do not make up prefixes. Claims with incorrect or missing prefixes and/or member ID numbers cannot be processed. See Claims Billing and Remittance module for details.

How do I submit claims for international Blue members?

The claim submission process for international Blue plan members is the same for domestic Blue plan members. Submit the claim directly to Blue KC.

How do I handle COB claims?

The providers must ask members for duplicate or COB coverage information, and shall notify Blue KC of any potential or actual duplicate COB coverage through Blue KC's claims filing practices.

After calling 1-800-676-BLUE (2583), or through other means, and it is discovered that the member has a COB provision in their benefit plan and Blue KC is the primary payer, submit the claim with information regarding COB to Blue KC.

If a Provider does not include the COB information with the claim, the member's Blue plan or the insurance carrier will have to investigate the claim. This investigation could delay

payment or result in a post-payment adjustment, which will increase administrative bookkeeping.

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

For members with Medicare primary coverage and Blue plan secondary coverage, submit claims to Medicare intermediary and/or Medicare carrier.

When submitting the claim, it is essential to 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.

Be certain to include the prefix as part of the member ID number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage and key to facilitating prompt payments.

When the remittance advice is received from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim to the appropriate Blue plan and the claim is in process. DO NOT resubmit that claim to Blue KC; duplicate claims will result in processing and payment delays.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue KC with the Medicare remittance advice. Blue KC also accepts electronic claims submissions.
- In some cases, the member ID card may contain a COBA ID number. If so, be certain to include that number on the claim.
- For claim status inquiries, check Providers.BlueKC.com or call BlueCard **Provider Hotline**. See Contact Resource Directory for details.

When will I get paid for claims?

Complete, accurate and clean claims shall contain all information required to allow Blue KC to adjudicate and pay the claim without further investigation. This information includes identification of member and Provider, correct Blue KC billing numbers, services provided and appropriate standard diagnosis and procedure codes.

Blue KC will either process and pay claims without returning claim to Provider, or return in a timely manner to request further information.

Payments should be made within 30 days after the claim is made final. Payor shall pay Provider for services in accordance with the payment rates or notify Provider of delay. Under provisions of RSMo 376.383, claims not paid within 45 days shall be subject to interest charges. Blue KC will notify Provider of incomplete claims in a timely manner.

If payment has not been received for a claim, do not resubmit the claim because it will be denied as a duplicate. This also causes member confusion because of multiple Explanations of Benefits (EOBs). Blue KC processes claims as quickly as possible, but claim processing times at various Blue plans can vary.

If either payment or a response regarding a payment has not been received, please call BlueCard **Provider Hotline** or visit Providers.BlueKC.com to check the status of a claim (see Contact Resource Directory)

In some cases, a member's Blue plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information, Blue KC may either ask for the information or give the member's plan permission to contact a Provider directly.

Who do I contact with claims questions?

Check Providers.BlueKC.com or call BlueCard **Provider Hotline**. See Contact Resource Directory for details.

How do I handle calls from members and others with claims questions?

If members contact a Provider, tell them to contact their Blue plan. Refer them to the front or back of their ID card for a customer service number.

Glossary of BlueCard Program Terms

Administrative Services Only (ASO)

ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

Blue KC receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions and makes payment to the local Provider.

Affordable Care Act

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

BCBS Website

The Blue Cross and Blue Shield Association's Website, www.bcbs.com, contains useful information for providers.

BlueCard Access®

A toll-free 800 number for all providers and members to use to locate healthcare providers in another Blue plan's area. This number is useful to refer the patient to a Provider or healthcare facility in another location. BlueCard Eligibility® 1-800-676-BLUE (2583).

A toll-free 800 number for providers to verify membership and coverage information and obtain prior authorization on patients from other Blue plans.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue plan's area the PPO level of benefits when they obtain services from a Provider or hospital designated as a BlueCard PPO Provider.

BlueCard PPO Member

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard Doctor and Hospital Finder Website

A website to locate healthcare providers in another Blue plan's area Providers.BlueKC.com. This is useful to refer the patient to a Provider or healthcare facility in another location.

BlueCard Worldwide®

A medical assistance program that provides Blue members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

Blue High Performance Network (BlueHPN℠)

A national network of providers offered in key geographies that provides national accounts enhanced quality and cost savings.

Consumer Directed Healthcare/Health plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, Provider and network information and financial incentives.

Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Co-payment

A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

Doctor and Hospital Finder Website

Providers.BlueKC.com

EPO

An Exclusive Provider Organization or EPO is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

Essential Community Providers

Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

FEP

The Federal Employee Program.

Hold Harmless

An agreement with a healthcare Provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare Provider has contractually agreed on with a Blue plan as full payment for these services.

Marketplace/Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA).

Medicaid

A program designed to provide healthcare to low-income adults, families, and their children. Medicaid also provides healthcare to low-income children under age six and low-income pregnant women. Medicaid is governed by Federal guidelines for eligibility, procedures, payment level etc., but within those guidelines, states have a broad range of customizations and states can apply for specific waivers. State Medicaid programs must be approved by CMS, and their daily operations are overseen by the State Department of Health (or similar state agency).

Medicare Advantage

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as traditional Medicare.

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred Provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare plan doesn't cover.

Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's home plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare

Advantage plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

National Account

An employer group with employee and/or retiree locations in more than one Blue plan's service area.

Other Party Liability (OPL)

Cost containment programs that ensure that Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes Coordination of Benefits, Medicare, Workers' Compensation, subrogation and no-fault auto insurance.

Plan

Refers to any Blue plan.

POS

Point of Service or POS is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care Provider/group and/or complies with referral/prior authorization requirements for care. Benefits are still provided when the member obtains care from any eligible Provider without authorization, according to the terms of the contract.

PPO

Preferred Provider Organization or PPO is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO Provider. The benefit program does not require a gatekeeper (primary care Provider) or referral to access PPO providers.

PPOB

A health benefit program that provides a significant financial incentive to members when they obtain services from any Provider or hospital designated as a PPO Provider and that does not require a primary care Provider gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other Provider types, such as Essential Community and Indian Health Service providers where they are available.

Prefix

Three characters preceding the subscriber ID number on the Blue plan cards. The prefix identifies the member's Blue plan or National Account and is required for routing claims.

Qualified Health Plan (QHP)

Under the Affordable Care Act, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts) and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Small Business Health Options Program (SHOP)

A Health Insurance Marketplace that allows employers to choose the level of coverage and offer choices among health insurance plans.

State Children's Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women and other adults.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

Kansas City

PROVIDER REFERENCE GUIDE

A Reference Manual for Blue KC Practitioners

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