Medicare for Other Blue Plans

Serving members of other Blue Plans with traditional (Original) Medicare and Medicare Advantage (HMO, POS, PPO, PFFS and MSA)



Kansas City

BLUE KC NETWORK PROVIDER REFERENCE GUIDE

A reference manual for all Blue KC contracted network providers.

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Medicare for Other Blue Plans

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Blue KC's Blue Medicare Advantage is an HMO plan with a Medicare contract. For information about the local Blue KC Blue Medicare Advantage plan, please visit Provider.BlueKCMA.com where you will find that Provider Administrative Manual.

Medicare Advantage Overview

Medicare Advantage (MA) offers Medicare beneficiaries several product options (similar to those available in the commercial market), including Health Maintenance Organization (HMO), Medical Savings Account (MSA), Private Fee-for-service (PFFS), Point of Service (POS) and Network Sharing Preferred Provider Organization (PPO) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by calling 1-800-676-BLUE (2583) or submitting an electronic inquiry via the Blue KC Provider Portal for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

Blue KC licensed providers must accept Medicare as form of payment. Blue KC, or the applicable Provider, will make payment only for Medicare cost sharing amounts.

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

Identification of Members

Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards.

Member ID cards for will display one of the benefit product logos here:

Health Maintenance Organization	MEDICARE ADVANTAGE | HMO
Medicare Advantage Medical Savings Account	MEDICARE ADVANTAGE | MSA
Private Fee-for-Service	MEDICARE ADVANTAGE | PFFS
Point-of-Service	MEDICARE ADVANTAGE | POS
Network Sharing Preferred Provider Organization	MA | PPO MEDICARE ADVANTAGE

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, Provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Note: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.

Types of Plans

Health Maintenance Organization (HMO)

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits and the coverage rules, may vary by Medicare Advantage plan.

Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

Private Fee-for-Service (PFFS)

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's Terms and Conditions of participation. Acceptance is "deemed" to occur where the Provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the Provider has reasonable access to the Terms and Conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the Provider is a network Provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might

Types of Medicare Advantage Plans

1. Health Maintenance Organization (HMO)
2. Medical Savings Account (MSA)
3. Private Fee-for-Service (PFFS)
4. Point-of-Service (POS)
5. Network Sharing Preferred Provider Organization (PPO)

currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Blue KC.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan and we advise that you review them before servicing MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- For your convenience, you will find MA PFFS Terms and Conditions for all Blue Plans at Providers.BlueKC.com by providing the member's three-letter alphanumeric prefix.
- Submit your MA PFFS claims to Blue KC.

Point-of-Service (POS)

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's Provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's Provider network.

Network Sharing Preferred Provider Organization (PPO)

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PPO Network Sharing

All (other Blue) Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO Provider.

Medicare Advantage PPO shared networks are available in the following states and territories:

Alabama	Maine	Oklahoma
Arkansas	Massachusetts	Oregon
California	Michigan	Pennsylvania
Colorado	Missouri	Puerto Rico
Connecticut	Montana	South Carolina
Florida	Nevada	Tennessee
Georgia	New Hampshire	Texas
Hawaii	New Jersey	Utah
Idaho	New Mexico	Virginia
Illinois (participating)	New York	Washington
Indiana	North Carolina	West Virginia
Kentucky	Ohio	Wisconsin

What does the BCBS Medicare Advantage PPO Network Sharing mean to me?

If you provide services for any Blue plan's Medicare Advantage PPO members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level.

How do I recognize an out-of-area member from one of these Plans?

You can recognize a MA PPO member when their Blue Cross Blue Shield member ID card has the following logo.

MA | PPO
MEDICARE ADVANTAGE

The "MA" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Plans?

You may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to (other Blue) Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount.

How do I verify benefits and eligibility?

You can check benefits and eligibility on the Provider Portal or by calling the BlueCard Eligibility Line at 1-800-676-BLUE (2583) and provide the member's three-digit alphanumeric prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members.

1. Log in to Provider's website.
2. Navigate to Eligibility Access.
3. Submit your request

What is the member cost sharing level and copayments?

A MA PPO member cost-sharing level and co-payment is based on the member's health plan.

You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1-800-676-BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be balanced billed for any deductibles, coinsurance or copays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact BlueCard Eligibility (see Contact Resource Directory).

Who do I contact if I have a question about MA PPO network sharing?

If you have any questions regarding the MA program or products, contact BlueCard Eligibility (see Contact Resource Directory).

Eligibility Verification

- Verify BlueCard eligibility by contacting BlueCard Eligibility (see Contact Resource Directory).
- Be sure to ask if Medicare Advantage benefits apply.

Claims Submission

- Submit all Medicare Advantage claims to Blue KC.
- Payment is made directly by a Blue Plan.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

Reimbursement

MA PPO, HMO and POS

Blue KC licensed providers must accept Medicare as form of payment. Blue KC, or the applicable Provider, will make payment only for Medicare cost sharing amounts. The reimbursement information in this section applies when a Provider treats a Medicare Advantage member enrolled through another Blue plan to whom the Provider's contract does not apply.

For example:

- A Provider contracted for MA PPO business treats a MA HMO member.
- A Provider contracted for commercial business only treats a MA PPO member.
- A Provider contracted for MA HMO business treats any MA PPO member.
- A Provider contracted for local MA HMO business treats an out-of-area MA HMO member.
- A Provider not contracted with the local plan treats a MA HMO member.

Based on the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a Provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted Provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services. This is the amount you would collect if the beneficiary were enrolled in traditional Medicare.

- Special payment rules apply to hospitals and certain other entities, such as skilled nursing facilities, that are non-contracted providers.
- Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.
- Providers paid on a reasonable cost basis under original Medicare should send their CMS interim payment rate letter with their Medicare Advantage claim. The Plan needs this letter to calculate the Medicare allowed amount.
- Other than the applicable member cost sharing amounts, a Blue Plan or its branded affiliate make reimbursements directly. In general, you may collect only the applicable cost-sharing (for example copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.
- Enrollee payment responsibilities can include more than copayments, for example deductibles.
- Please review the remittance advice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

MA Private Fee-For-Service (PFFS)

If you have rendered services for Blue out-of-area MA PFFS members, but have no obligation to provide services to such members under a contract with a Blue plan, you are generally reimbursed the Medicare allowed amount for all covered services. This is the amount you would collect if the beneficiary were enrolled in traditional Medicare. Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms and Conditions under the member's Blue Plan. You can find the MA PFFS Terms and Conditions on the

Provider portal at Providers.BlueKC.com. Select the link to the Medicare Advantage Provider Portal, log in and then enter the member's three-letter alphanumeric prefix.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (for example copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Provider shall only collect all member copayments, coinsurance, cost share, or deductible amounts after services are rendered, and shall not waive such amounts. The payment rate agreed upon must be accepted as payment in full of payor's financial responsibility. Blue KC shall make remaining payments directly to Provider for covered services. Provider cannot bill member for the difference between full charges and payment rate, and can only bill, charge or collect remaining cost from Blue KC. The Provider accepts the payment rate as payment in full of the payors financial responsibility for services provided to members.

Provider can negotiate arrangements with the member for payment of Copayment, coinsurance, cost share, or deductible, but providers shall not accept payments from any third parties.

Please review the remittance advice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations If you are a Provider who accepts Medicare assignment and you render services to any Medicare Advantage member enrolled with another Blue plan for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted Provider and be reimbursed per the contractual Agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual plan contractual arrangements.

Claims Submission and Utilization Review

Utilization review is a process to understand all aspects Provider services including: prior authorization, quality improvement, concurrent review, case management and respective review. Prior authorization is the process used to determine the appropriateness of services provided to members and payments made on behalf of members. Patients are responsible for obtaining prior authorization for their services from their Blue Plan.

When the length of an inpatient hospital stay extends past the previously approved length of stay, any additional days must be approved. Failure to obtain prior authorization for the additional days may result in claims processing delays and potential payment denials. You can also contact members' plans on their behalf.

For other Blue Plans members, do one of the following:

- Call BlueCard Eligibility then ask to be transferred to the utilization review area.

The member's Blue Plan may contact you directly about clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

Traditional Medicare-Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is the primary payor, submit claims to your local Medicare intermediary.
- All Blue claims are set up automatically to cross-over to the member's Blue Plan after adjudication by the Medicare intermediary.

Submitting Medicare Primary/Blue Plan Secondary Claims

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

- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification. In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- Include the alphanumeric prefix as part of the member identification number. The member's ID includes the alphanumeric prefix in the first three positions. The alphanumeric prefix is critical for confirming membership and coverage, and is key to facilitating prompt payments.

Claims Status Inquiries

You can make claim status inquiry on the Provider portal by doing a claims search or a contact us, submit an inquiry claims ITS (where and how?).

Payment Expectations

Claims submitted to the Medicare intermediary are crossed over to the Blue Plan only after they have been processed, which may take up to 30 business days. This means that the Medicare intermediary releases the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 30 business days for you to receive payment from the Blue Plan. After receiving the remittance advice 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 on your behalf to the appropriate Blue Plan and the claim is in process.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to Blue KC with the Medicare remittance advice.

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.

Payment Timeline and Submission

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, do not submit another claim.

Duplicate claims will result in processing and payment delays. Instead, you should:

1. Wait 30 days.
2. Check claims status before resubmitting.
3. Review the automated resubmission cycle on your claim system.

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

All overpayments or incorrect payment of either parties must be identified and recovered with no time limitation. However, Provider must send refunds to members within 30 days after receiving recovery payment from Blue KC.

Blue KC will recover any overpayments, payments related to billing code errors or incorrect payments by credit transactions on the remittance advice form either fee-for-service payments. Blue KC may offset the full amount of any incorrect payment and reissue payment for the correct amount.

If Provider does not dispute a specific payment writing within 90 days of receiving payment, Provider is deemed to have accepted the payments and waived the right to dispute.

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. For claims for services rendered to a member under the Federal Employee Health Benefits Program (FEP) some adjustments are possible even after the 90 day period.



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D/25074_4/25