Inter-Plan Operations (BlueCard®)
Sharing our success

An independent licensee of the Blue Cross and Blue Shield Association
Agenda

• History of BlueCard®
• Claim reminders
• Program performance
• Claim tips
• On the horizon → What improvements are coming?
• Contacting us
BlueCard history
BlueCard® history

• The BlueCard® Program began in 1994 and was designed to enable members traveling or living in another Plan’s service area to receive their at home benefits while away.

• BlueCard® allows members to receive the same provider discounts negotiated by the Host Plan (i.e., BCBSNC).

• BlueCard® links participating providers and independent BCBS Plans across the country electronically for claims processing and reimbursement.
BlueCard® history (continued)

Who do we service?

• From 1994 through 2007 BlueCard® enrollment has grown from 64 million members to 100,200,000 in 2008 network wide

• 910,000 Hosted members reside in North Carolina, making Blue Cross and Blue Shield of North Carolina (BCBSNC) the 3rd largest Host Plan
  – 10,363,974 Host claims processed
  – 3,337,785 Home claims processed
Inter-Plan Programs

• The BCBSNC department that services BlueCard members has other responsibilities related to the communications & activities between the BCBS Plans

• The department changed its name to Inter-Plan Programs during July 2006 to accommodate the functions of all Plan-to-Plan programs
Claim reminders
Claim reminders (members)

• Utilize a participating provider
• Carry and ensure that the provider has a copy of their most current ID card
• Ensure any “pre-certifications” are obtained
• Member appeals must be initiated to the member’s benefit plan
Claim reminders (providers)

• Review the ID card to ensure that the card is current
• Validate the member’s eligibility and benefits
• Submit claims with correct patient information, which includes:
  − Correct ID number, submit as listed on the card
  − File claim with all pertinent information required to enable BCBSNC to price the claim, e.g., modifiers, CPT codes
Claim reminders (BCBSNC)

- Accept claims from all NC participating providers
- Price and submit all claims to the member’s benefit plan for adjudication
- Administer any request for information between the member’s benefit plan and the provider
- Process the payment and/or denial received from the member’s benefit plan to the NC provider
- Be a liaison for all “claim status” between our NC providers and the member’s benefit plan
Claim reminders (member’s benefit plan)

• The member’s benefit plan is accountable for:
  – Membership validation
  – Applying benefits
  – Adjudicating or denying the claim
  – Eligibility related inquires

*The buck stops here!!!*
2007
Inter-Plan Program
Performance
Inter-Plan Performance

- During 2007 IPP received 10,963,974 Host claims, representing $2,091,951,987.30 of processed dollars.
- Implementing programs to pay 99% of original claims within 30 calendar days.
Inter-Plan Performance (continued)

• In addition, during 2007 Inter-Plan Operations handled:
  - 301,315 Inquires and phone calls were received and resolved through regular customer service
  - 32,383 Inquires were handled through the Plan to Plan Unit
  - 28,103 Callbacks were made on follow up inquires
Claim tips
How can you help reduce the cycle time on aged claims?

• Correct claims filing:
  − Make sure that all patient ID #’s and prefix’s are current and correct, and submit this information as it appears on the ID card
  − Make sure that all pertinent information is included on the claim that will allow BCBSNC to price the claim appropriately

• For NOC procedures, provide a description of the services. This information can be documented electronically on:
  • For 837 professional claims at the “line” level, this information can be found at loop 2400, this is in the “NTE” segment.
  • For 837 institutional claims there is no specific loop or element, however to report at the “claim” level, this information can be provided at loop 2300, this is for in the “NTE” segment.
  • For “unlisted” DME procedures, including the invoice with the claim will help expedite processing.
Claim tips (continued)

Solicited Medical Records
• Currently there are 3 methods to request and receive solicited medical records
  − USPS, Fax, and Online (Provider Link)
  − The most preferred method is “online” or “fax”
Claim tips (continued)

- Consider your costs of not responding to “solicited” medical records requests:
  - **Provider**
    - Not submitting the information within 10 days
    - Submitting without the BCBSNC cover sheet
    - Not sending the requested information
      - This results in aged provider A/R and potential loss of revenue.
      - Additional administrative expenses
  - **BCBSNC**
    - Additional administrative expenses
    - Delays in processing claims due to multiple requests being sent to the provider
      - Increases member dissatisfaction
Claim tips (continued)

• It is extremely important that the medical record request is read in its entirety to ensure that the BCBS home-plan receives what they need the first time
  - This reduces multiple record submissions and or phone calls to the call centers, which results in delays in determining BCBSNC liability on the claim
Other opportunities …

• Please ensure that all unsolicited refund request submitted to BCBSNC are printed in black ink and legible
• File claims electronically as much as possible !!!
Making things easier – What we’ve done!
Preauthorizations

Scenario:

- If the provider had acquired preauthorization prior to treating the member and the member’s BCBS home-plan denies the claim because records stating that preauthorization was requested cannot be located

What is new …

- BCBSNC can now validate that the preauthorization was received over the phone
Benefit plan requiring member information

Scenario
  • To minimize claim denials due to lack of member’s COB information

What is new …
  • The COB questionnaire is now available online
  • Providers can access and provide a copy to the member to capture COB information
  • Providers can use supplied information on the claim
  • Member can forward the completed form to their benefit plan
Medicare primary

Scenario:
• A provider wishes to research the status of a Medicare cross-over claim

What is new …
• The provider can contact BCBSNC’s BlueCard® Customer Service directly
• BCBSNC will connect the provider (soft transfer) to the member’s benefit plan, or facilitate a conference call for the provider to obtain status
Coming soon!
Coming soon!

• End to end
  – New claim adjudication performance metrics
  – Drives host and benefit plan collaboration
• Blue² → November 2008
  – Simplify the preexistence information requests
• COB → January 2009
  – Providers can be proactive if acquiring COB information from the member
• BlueCard® Member and/or Provider Appeals
Resources
Resources

• Blue e℠

• BlueCard® Customer Service 1-800-487-5522

• Submit general written inquiries to:
  BCBSNC
  Inter-Plan Correspondence
  P.O. Box 2291
  Durham, NC 27702-2291

• Submit Unsolicited Refunds inquiries to (before sending a check):
  BCBSNC
  Inter-Plan Correspondence
  ATTN: Host Refund Inquiries
  P.O. Box 2291
  Durham, NC 27702-2291
Questions ???
Acronyms

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BCBS</td>
<td>Blue Cross and Blue Shield</td>
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<tr>
<td>BCBSNC</td>
<td>Blue Cross and Blue Shield of North Carolina</td>
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<tr>
<td>COB</td>
<td>Coordination of Benefit</td>
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<tr>
<td>CPT</td>
<td>Current Procedural Terminology</td>
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<td>DME</td>
<td>Durable Medical Equipment</td>
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<td>ID</td>
<td>Identification</td>
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<td>NC</td>
<td>North Carolina</td>
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<tr>
<td>NOC</td>
<td>Not Otherwise Classified</td>
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<tr>
<td>USPS</td>
<td>United States Postal Service</td>
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Definitions

Benefit Plan  Home Plan. The Plan that houses the member’s benefits and eligibility