

Chapter 5

BlueCard Program (out-of-state claims)

How the BlueCard Program Works

Introduction

The BlueCard Program is a national program that enables members traveling or living in another Blue Cross Blue Shield (BCBS) Plan's area to receive the same benefits and BCBS provider access. The BlueCard Program allows health care providers to submit claims for members from other BCBS Plans, including international BCBS Plans, directly to BCBSMT. BCBSMT is the primary point of contact for most claims-related questions.

The BlueCard Program links participating health care providers and the independent BCBS Plans across the country and around the world through a single electronic network for claims processing and compensation. Over 65,000 out-of-state members living in Montana have claims processed through the BlueCard Program.

Products and Services Included in the BlueCard Program

The BlueCard Program applies to all inpatient, outpatient, and professional claims. Traditional, Preferred Provider Organization (PPO), Point-of-Service (POS), and HMO products are included in the BlueCard Program.

Products and Accounts Excluded from the BlueCard® Program

The following products are excluded under the BlueCard Program:

- Caring Program for Children
 - Federal Employee Program
 - Stand-alone dental and prescription drug programs
 - Medicare crossover claims
 - Canadian Association of Blue Cross Plans
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Exceptions to BlueCard Claim Submission

Rare exceptions may arise in which BCBSMT requires you to file the claim directly with the member's BCBS Plan. For example, if the ID card does not include an alpha prefix, the claim is from an exempt plan such as FEP. **Follow the claims filing instructions noted on the card.**

Other exceptions may include a temporary processing issue at BCBSMT, the member's Blue Plan, or both prevents processing of the claim through the BlueCard Program.

Member Eligibility

How to Identify BlueCard Members

When members from other Blue Cross and Blue Shield Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix and a blank suitcase logo. Note that for eligible PPO members, "PPO" will appear in the suitcase logo.

Alpha Prefix

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route out-of-state claims. The alpha prefix identifies the BCBS Plan or national account to which the member belongs and is critical for confirming a patient's membership and coverage.

There are two types of alpha prefixes: plan-specific and account-specific.

1. **Plan-Specific** alpha prefixes are assigned to every plan and start with X, Y, Z or Q. The first two letters indicate the plan while the third letter identifies the member's product.
 - First character (X, Y, Z or Q)
 - Second character (A-Z)
 - Third character (A-Z)
2. **Account-Specific** alpha prefixes are assigned to centrally processed national accounts. National accounts are employer groups that have offices or branches in more than one area but offer uniform benefit coverage to all of their employees. Account-specific alpha prefixes start with letters other than X, Y, Z, or Q. Typically, a national account alpha prefix will relate to the name of the group. All three letters are used to identify the national account.

Identification Cards With No Alpha Prefix

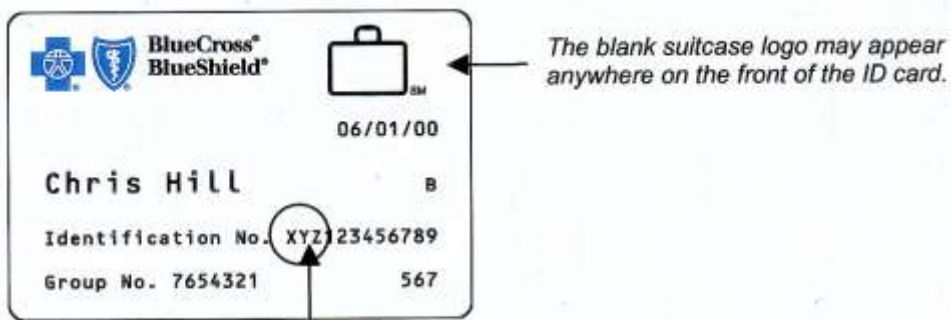
Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Look for instructions or a telephone number on the back of the member's ID card for information on how to file claims. If that information is not available, call Customer Service at 1-800-447-7828.

Suitcase Logo

A suitcase logo on a member's ID card means the patient has BCBS traditional, PPO, or HMO benefits delivered through BlueCard. Some plans may adjust benefits according to the home plan's benefit structure.

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How to Identify BlueCard Members, continued



The easy-to-find alpha prefix identifies the member's Blue Cross and Blue Shield Plan.

Health Debit Cards

Some members may have a Blue Cross and/or Blue Shield health care debit card with value-added features to assist your office with collecting member cost-sharing amounts. Using the new cards can help simplify the payment process and help you:

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

Stand-Alone Debit Cards and Combined Debit and Member ID Cards

The card allows members to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA), or Flexible Spending Account (FSA). Some cards are “stand-alone” debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number.

The card will have the nationally recognized Blue Cross and/or Blue Shield logos, along with the logo from a major debit card logo such as MasterCard® or Visa®.

The cards include a magnetic strip so providers can collect any deductibles, copayment, or coinsurance through any debit card swipe terminal. Funds are deducted automatically from the member’s appropriate HRA, HSA, or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements and can also use their cards via phone to process payments. In addition, members are more likely to carry their current ID cards because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment. The cost is the same as the current cost you pay to swipe any other signature debit card.

Sample Stand-Alone Debit Card



Sample combined Debit Card and Member ID Card



How to Identify International Members

Occasionally you may see identification cards from foreign BCBS plan members. These ID cards will also contain three-character alpha prefixes. Treat these members the same as domestic BCBS plan members.

The Canadian Association of Blue Cross Plan and its members are separate and distinct from the Blue Cross and Blue Shield Association in the United States. Claims for members of Canadian Blue Cross Plans are not processed through the BlueCard Program. Follow the instructions on the member's ID card.



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BCBSMT is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

**How to Verify
Membership
and Coverage**

**To verify membership, call 1-800-676-BLUE (2583)
or register online at www.bcbsmt.com and click on BlueExchange**

Operators are available to assist you during regular weekday business hours (7 a.m. – 10 p.m. EST). They will ask for the alpha prefix shown on the member's ID card and will connect your office directly to the appropriate membership and coverage unit at the member's BCBS Plan.

Keep in mind that BCBS plans are located throughout the country and may operate on a different time schedule than BCBSMT. If you call after hours, a recorded message will state normal business hours and you may be transferred to a voice response system linked to eligibility and benefits.

Provider offices registered at www.bcbsmt.com to view benefits, claims, and eligibility information may click on BlueExchange to quickly and securely verify eligibility for out-of-state BCBS and Federal Employee Program members.

BlueCard Claims Administration

**How to Prior
Authorize and
Precertify**

Remind patients *they* are responsible for obtaining prior authorization for services from their BCBS Plan; however, your office may choose to contact the member's Plan on his or her behalf.

Effective April 1, 2010, if you are calling to precertify or preauthorize your patient, your call will be routed directly to the area that handles precertifications and preauthorizations. You will choose from four options regarding the type of service for which you are calling:

- Medical/surgical
- Behavioral health
- Diagnostic imaging/radiology
- Durable medical equipment (DME)

Upon making your selection, you will be transferred to the appropriate area of the member's Plan to handle your specific request.

If you are calling 1.800.676-BLUE (2583) to obtain eligibility only or if you need both eligibility and precertification or preauthorization, your call will be handled like it is today. You will select the option to obtain eligibility and precertification/preauthorization information. First, your eligibility inquiry will be addressed. Then you will be transferred, as appropriate, to the precertification/preauthorization area.

If you have any questions about the BlueCard Eligibility line (1.800.676.BLUE), please email your Provider Network Service Representatives at HCS-X6100@bcbsmt.com or call 1-800-447-7828, Extension 6100.

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**How to Submit
BlueCard
Program
Claims**

The BlueCard Program provides a valuable service that lets you file claims through BCBSMT for members from other BCBS Plans.

Step	Action
1	Make a copy of the front and back of the member's ID card.
2	Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
3	Call BlueCard Eligibility at 1.800.676.BLUE (2583) to verify membership and coverage.
4	Submit the claim to BCBSMT with the alpha prefix. BCBSMT electronically routes the claim to the member's BCBS Plan. The member's Plan then processes the claim and approves payment. BCBSMT will send a check along with your weekly Provider Claims Register.

**Medical
Records**

When medical records are required to process a claim, requests will come from BCBSMT, and BCBSMT will work with the member's Blue plan. Do not proactively send medical records with claims unless requested. Unsolicited claim attachments may cause claim payment delays. Direct any questions regarding medical records to 1-800-447-7828.

**International
Claims**

The claim submission process for international BCBS Plan members is the same as for domestic members. Submit the claim directly to BCBSMT.

Ancillary Providers

An Ancillary/Remote Provider is an independent clinical laboratory (Lab), durable/home medical equipment (DME) supplier and specialty pharmaceutical provider. Claims for services rendered by these provider types should be submitted as follows:

Provider Type	Submits to....
Independent Clinical Laboratories (Labs)	The Plan in whose services area the specimen was drawn.
Durable/Home Medical Equipment (DME)	The Plan in whose services area the equipment was shipped to or purchased at a retail store.
Specialty Pharmacy	<p>The Plan in whose services area the ordering physician is located.</p> <ul style="list-style-type: none">• Specialty Pharmacy is characterized as non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the Plan's Specialty Pharmacy formulary.• Specialty Pharmacy generally includes injectables and infusion therapies, high-cost therapies, and therapies that required complete care. Examples of major conditions these drugs treat include, but are not limited to, cancer, HIV/AIDS and hemophilia.

Coordination of Benefits (COB)

COB ensures 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.

If, after calling BlueCard Eligibility or through other means, you discover the member has a COB provision in the benefit plan and BCBSMT is the primary payer, submit the claim along with information regarding COB to BCBSMT. If you do not include the COB information with the claim, the member's BCBS plan or the insurance carrier will need to investigate the claim, and this will delay payment or result in a post-payment adjustment.

Medicare Supplement (Medigap) Claims

Always file Medicare supplemental claims with the Medicare contractor first to ensure crossover claims are forwarded appropriately. Always include the following:

- The complete Medicare HIC number
- The patient's complete BCBS plan identification number, including the three-character alpha prefix
- The BCBS plan name as it appears on the patient's ID card

Do not submit claims to BCBSMT and Medicare simultaneously. File with Medicare first and wait until the Explanation of Medical Benefits (EOMB) or payment advice is received from Medicare. If the claim automatically crosses over to the member's home plan, there is no need to file a claim with BCBSMT.

If the claim has not crossed over to the member's home plan, send a paper claim along with the Medicare EOMB to BCBSMT. BCBSMT, or the member's BCBS plan, will pay you the Medicare supplemental benefits. If assignment is not accepted, the member will be paid, and you may bill the member.

Note: Some Medicare supplemental benefits will be paid by other plans. However, continue to submit claims to BCBSMT.

Who to Contact for Claim Questions

Call BCBSMT at 1-800-447-7828 to check on the status of your claim or to get your questions answered.

Do not resubmit the claim because the claim will be denied as a duplicate. The member's plan should not be contacting you directly unless you filed a paper claim directly with that plan. If the member's Plan contacts you to send them another copy of the member's claim, refer them to BCBSMT.

In some cases, a member's BCBS Plan may suspend a claim because medical review or additional information is necessary. When resolution of a claim requires additional information from your office, BCBSMT may either ask for the information or give the member's plan permission to contact your office directly.

If members contact your office, instruct them to contact their BCBS plan. Refer them to the front or back of their ID card for a Customer Service number.
