South Carolina

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BLUECARD PROGRAM

DISCLAIMER

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AGENDA

- Overview
- Home Plan
- Host Plan
- Ancillary Claims

OVERVIEW

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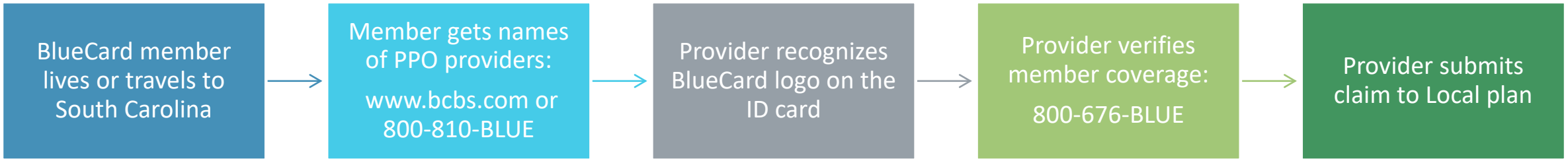
Overview

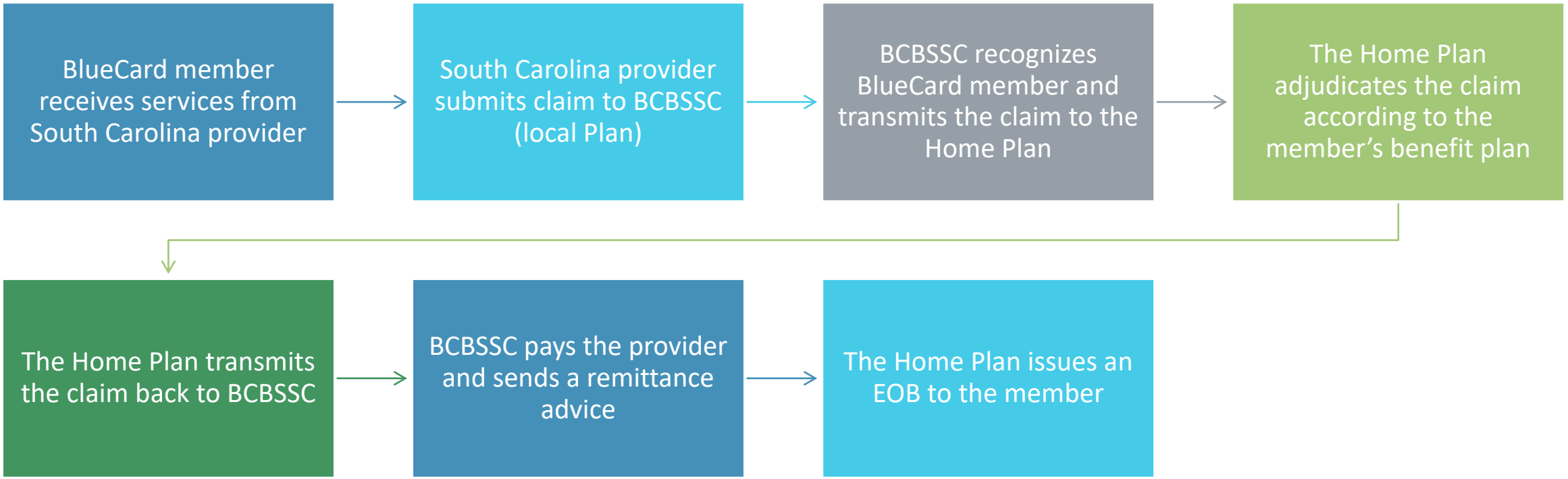
The BlueCard Program:

- Allows Blue Plan members to receive health care service benefits and savings while traveling or living in another Blue Plan's service area.
- Permits providers to submit claims for other Blue Plan members directly to their Local plan for processing.

ELIGIBILITY AND BENEFITS PROCESS



CLAIMS PROCESS



MEMBER ID CARDS – SUITCASE LOGOS

- Empty suitcase
  - Indicates the member is enrolled in either a traditional, HMO, POS or limited benefit product
- BlueHPN suitcase
  - Indicates the member is enrolled in an EPO product with access to the Blue High Performance Network
- PPO suitcase
  - Indicates the member is enrolled in a PPO or EPO product (the back of the care may identify limitations for EPO members)
- PPOB suitcase
  - Indicates the member has access to the exchange PPO network, referred to as BlueCard PPO Basic (used for members on exchange products sold by Blue Cross and Blue Shield plans)

HOME PLAN

HOME PLAN – GENERAL RESPONSIBILITIES

The Home plan is responsible for handling all interactions with their accounts, members and other carriers.

For Members, the Home Plan:	For Providers, the Home Plan:
Controls all aspects of benefit plan delivery	Provide eligibility and benefit determination
Issues member ID cards and Explanation of Benefits (EOBs)	Handles utilizations management/care management
Handles all member and account inquiries	
Adjudicates claims according to member benefits	

HOME PLAN – ELIGIBILITY AND BENEFITS

The Home plan is responsible for providing eligibility and benefits to providers. Below are two methods that can be used to verify this information.

BlueCard Eligibility Line (800.676.BLUE):	Electronically through the BlueExchange:
A centralized phone service that transfers providers to a member's Home Plan to obtain eligibility, benefits and pre-service review information	BlueExchange is an electronic inter-Plan clearinghouse for managing the flow of HIPAA-compliant transactions between Plans
Plans provider BCBSA with the phone numbers necessary to route providers to the appropriate area of the Home Plan using the member's prefix	Supports real-time and batch processing of several types of healthcare transactions including 270/271 (Health Care Eligibility Benefit Inquiry and Response)

HOME PLAN – CARE MANAGEMENT

The Home plan is responsible for administering all care management for their members nationally.

The Home plan must:
Educate members about care management programs, including the member's responsibilities
Train staff in handling interactions with the Host Plan's providers
Interact with out-of-area providers in pre-service, pre-claim situations deemed as urgent, to collect clinical/medical information needed for utilization review/utilization management processes for a specific member's case
Reply to out-of-area providers' pre-service review requests within no more than 72 hours for urgent cases and 15 business days for non-urgent cases
Handle inquiries/requests and reviews from members or provider on their behalf
Coordinate member and provider on member's behalf appeals

CARE MANAGEMENT – PRE-SERVICE REVIEW

The Home plan must:
Post on their website, at a minimum, general pre-service review requirements for all inter-Plan prefixes (not applicable to Federal Employee Program (FEP) or Medicare Advantage) and make it available to out-of-area providers via the Medical Policy Router
Allow electronic access, via the Pre-Service Review Router, to out-of-area participating providers to conduct pre-service review when such capability is made available to their local providers

CARE MANAGEMENT – MEDICAL, BENEFIT AND PAYMENT POLICY

- The Home plan applies medical policies and benefit policies to claims in accordance with the member/account contract benefits and its local practices.
- The Home plans' medical policies apply to the interpretation and determination of medical necessity, investigational/experimental care and clinical reviews.

HOME PLAN – MEDICAL RECORDS

The Home plan must request medical records only in limited circumstances (e.g., when needed to process a claim).

The Home plan must:
Review criteria for requesting medical records annually.
Comply with BlueSquared medical record request requirements.
Verify if medical records are on file, or have been previously requested before sending a medical record request to the Host Plan
Send the appropriate BlueSquared Information Message when records have been previously requested on a related claim
Ensure the request is for the correct provider (e.g., referring provider versus rendering provider, in the case of a lab) and is as specific and accurate as possible

HOME PLAN – CLAIM APPEALS AND PROVIDER RECONSIDERATIONS

Claim appeals or provider reconsiderations are post-service requests for reconsideration of a previously adjudicated claim.

The Home plan must:
Resolve member appeals and communicate outcomes to the member and/or provider
Notify the Host Plan when a member appeal is received directly from a provider
Pursue the member if an authorization is required for member appeals
Have processes in place to request and review medical records related to a claim appeal
Respond to the BlueSquared General Inquiry message (sent by the Host Plan) within 30 calendar days of receipt

HOST PLAN

HOST PLAN – GENERAL RESPONSIBILITIES

The Host plan is responsible for all provider-related functions and interactions with their providers.

The Host plan will:
Service all providers in their service areas (including participating, nonparticipating and contracted ancillary providers
Respond to all claim-related inquiries from their providers
Manage provider contracting and educations
Receive and price claims (including those from non-contracted providers)
Reimburse providers as appropriate

HOST PLAN – ELIGIBILITY AND BENEFITS

- The Host plan is responsible for educating providers on how to verify member eligibility and benefits for their out-of-area patients.
- For providers to request eligibility and benefits electronically, the Host plan must provide the capability for their provider to submit HIPAA standard transactions supported by BlueExchange.

HOST PLAN – CARE MANAGEMENT

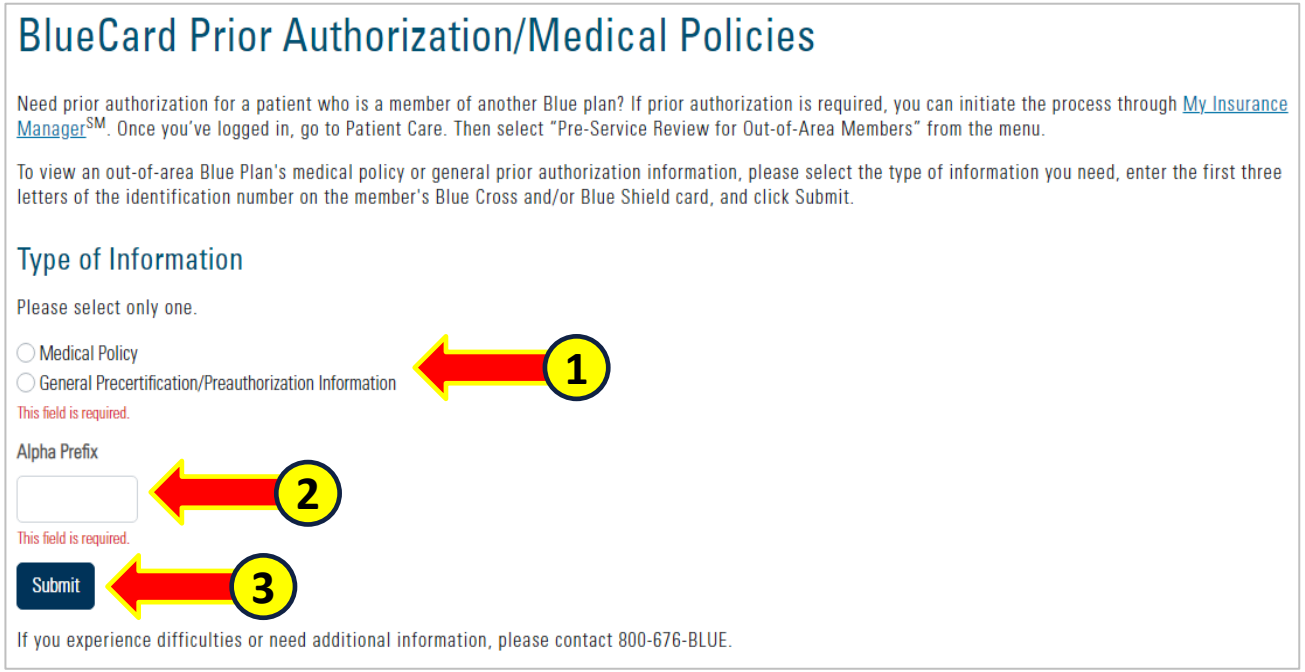
The Host plan is responsible for supporting the administration of care management.

The Host plan must:
Educate providers about how care management for out-of-area members is handled. This process may differ from what your Plan requires providers to do for local members.
Identify Host Plan care management contacts who will respond to inquiries from Home Plans
Obtain medical records, store them and transmit them appropriately to the Home Plan upon request
Actively assist providers in reporting and resolving problem cases or recurrent issues
Support providers as they assist members in complying with utilization review/utilization management requirements

CARE MANAGEMENT – PRE-SERVICE REVIEW

Pre-service reviews are commonly referred to as precertification, preauthorization or prior approval.

The Host plan must:
Provide website access for their providers to view the Home Plans' pre-service review requirements via the Medical Policy Router
Provide website access for their local participating providers to conduct pre-service review for out-of-area members



CARE MANAGEMENT – MEDICAL, BENEFIT AND PAYMENT POLICY

- The Host plan applies payment policies in accordance with its provider's contract.
- The Home plan should not impose its local billing rules or requirements on the Host plan's providers.

HOST PLAN – CLAIM FILING AND PRICING

- The Host plan must educate providers in their service area to file all claims with their local (Host) plan.
- The Host plan must accept and accurately price all claims received from participating and nonparticipating providers in their service area, in accordance with their provider contracts and Inter-Plan Programs policy requirements.

Note: Exceptions include:

- *Dental claims (other than services covered under medical benefits), and standalone vision and self-administered prescription drugs delivered through an intermediary model should be filed according to the instructions on the back of the ID card.*
- *Medigap claims should be filed to the Medicare intermediary which will electronically cross the claim over to the member's Home plan.*

HOST PLAN – MEDICAL RECORDS

The Host plan must obtain medical records from providers when requested by the Home plan.

The Host plan must:
Upon receipt of a medical record request, verify if records are already on file or have been previously requested
Be specific and not use acronyms or local jargon when requesting medical records from the provider
Ensure they are sending medical records requests to the correct provider and correct address/department within the provider's facility
Encourage their providers to respond to their requests for medical records within 10 days
Have a process in place to track open requests for medial records

HOST PLAN – PROVIDER RECONSIDERATIONS

A provider reconsiderations are post-service requests for reconsideration of a previously adjudicated claim.

The Host plan must:
Resolve provider reconsiderations and communicate outcomes to the provider
Have processes in place to promptly request medical records from providers related to a claim appeal and route them to the Home plan
Educate providers on correct filing instructions upon receipt of a BlueSquared Claim Appeal Misroute
Submit a BlueSquared General Inquiry within three business days of receipt of a provider reconsideration

ANCILLARY GUIDELINES

ANCILLARY GUIDELINES

Durable Medical Equipment (DME)

- File to the Plan whose state the equipment was purchases at a retail store; or
- File to the Plan whose state the equipment was shipped

Independent Clinical Laboratory

- File to the Plan where the specimen was drawn.
- The location of where the specimen was drawn is determined by the physical location of the referring provider.

Specialty Pharmacy

- File to the Plan whose state the ordering physician is located

THANK YOU