2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 12

Blue Cross Blue Shield

Introduction

Blue Cross Blue Shield (BCBS) is a nationwide insurance company offering a variety of health insurance products including group and individual policies. BCBS has partnered with the federal government to process Medicare fee-for-service claims. The BCBS Federal Employee Program (FEP) covers more than 5.6 million federal government employees, dependents, and retirees. Nationwide, more than 96 percent of hospitals and 95 percent of professional providers' contract with Blue Cross Blue Shield companies.

Common Types of Insurance Plans

Blue Cross Blue Shield offers a wide variety of insurance plans. Some of the common types include:

Health Maintenance Organization (HMO)—A type of health benefits plan where members are required to receive healthcare only from providers that are part of the HMO network.

Medicare—Blue Cross Blue Shield offers a Medicare Advantage plan - a federally funded health insurance, typically for those aged 65 and over, or for people under 65 who are disabled or meet other special criteria.

Preferred Provider Organization (PPO)—A plan that allows members to choose any provider but offers higher levels of coverage if members receive services from healthcare providers in the plan's PPO network.

Indemnity—Also known as traditional insurance or fee-for-service. Indemnity is a traditional insurance plan that reimburses for healthcare services provided to members based on providers' bills submitted after the services are rendered.

Point of Service (POS)—Point-of-Service coverage is a healthcare option that allows members to choose medical services as needed, and whether they will go to a provider within the Blue Cross Blue Shield network or seek medical care outside of the network.

Medicaid—A joint federal and state program that provides hospital expense and medical expense coverage to the low-income population and certain aged and disabled individuals.

There are also supplement accounts that are available. These are not actual insurance plans but accounts that are used for qualified medical expenses that are not covered. Pre-taxed money in these accounts is used to assist with the large deductibles and out-of-pocket expenses that many plans have today. Some of these accounts include:

Flexible Spending Accounts (FSA)—An account that reimburses employees for specified expenses as expenses are incurred. The funding for FSAs is usually through deductions from the employee's paychecks.

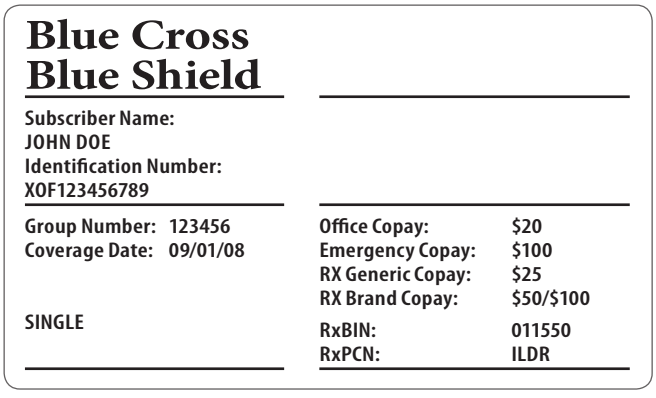
Health Savings Account (HSA)—An account that reimburses employees for specific healthcare expenses. The money contributed to your HSA belongs to you and can be used to cover eligible, current or future medical expenses. Funding for HSAs can be by the BCBS company member, an employer, or anyone else.

Health Reimbursement Arrangements (HRA)—An account that reimburses employees for specific healthcare expenses as expenses are incurred. Funding for HRAs is provided by employers.

Blue Cross Blue Shield Member Card

Blue Cross Blue Shield member card is a card the insurance company issues to each member to carry for identification. This card needs to be presented each time a member is seen by a healthcare provider when care is needed and pharmacists when a prescription needs to be processed. The insurance card contains information required to ensure claims are submitted and paid properly. Below is an example of what is found on a BCBS card. The look of the card and how the information is laid out on the card may vary depending on the type of plan.

Front



Sample image of the front of a PPO BCBS card

Typically, the following information will be found on the front of the card:

Plan: The type of insurance and the type of plan (such as PPO, HMO, POS, traditional, etc.) is listed at the top of the card.

Subscriber (SUB): The subscriber is the person who pays for the health insurance or whose employment makes him or her eligible for group health insurance.

Member: The person who is eligible for covered services.

Medical Network: The name of the healthcare provider network.

Identification Number: The number used to verify eligibility and coverage. The three letters preceding the identification number are required for processing claims. The two numbers at the end of the identification number are the suffix and this number indicates the member's relationship to the subscriber.

Group Number: Used to identify the benefits of the plan.

Rx Group Number: The number pharmacists use to process prescriptions.

Copay: Copayments are listed on the front of the card. These amounts show the amount that the member pays the healthcare provider on the day of service. PCP is the amount paid to the primary care physician. SP is the amount that is paid to a specialist. ED is the amount paid to the emergency department.

The back of the insurance card is just as important as the front. The back includes helpful instructions for the member, provider, and pharmacists, including claims submission address and telephone numbers. The information on the back of the card will vary depending on the plan.

Back

Blue Cross Blue Shield

Member Service/Benefit Questions: Call 1-800-123-4567.
Providers: All claims should be submitted to your local Blue Cross and Blue Shield plan.
Blues on Call: Call 1-800-Blue-789 for 24-hour access to nurses who provide health education and support services.
To Receive High Level Benefits: You must receive care from a network provider. If you choose to receive care through an out-of-network provider, for other than emergency care, you will receive payment at a reduced level of benefits.
Admissions: For Mental Health/Substance Abuse call 1-800-245-6789, for all other admissions call 1-800-876-1234.
Member Submitted Claims: If the provider does not submit your claim to their local Blue Cross/Blue Shield plan, send your claim to Blue Cross Blue Shield, P.O. Box 5432, Anywhere, UT 13456-9844.

Customer Service: 1-800-123-4567

Blue Cross And Blue Shield Geography

BILLING TIP

Obtaining a copy of an insurance card, front and back, is imperative. If the information is entered into the practice management system incorrectly or additional information is needed, it can be found on the insurance card.

BCBS of Texas reiterates the importance of obtaining a copy of the insurance card with the following claims filing tips:

- Obtain a copy of the member's current insurance card at all visits, as policies can often change. This will ensure that the claims are submitted with the most current policy information.
- Verify the correct alpha prefix is on all claims - this is extremely important. Many claims cannot be processed without the member's alpha prefix.

Source: https://www.bcbstx.com/provider/claims/claim_delays.html

Contractual Requirements

A participating provider is a healthcare provider, hospital, or entity that has agreed to provide healthcare services to an insurance plan's enrollees. A participating provider must be contracted with the insurance plan's network.

Credentialing is the process which BCBS reviews and validates the professional qualifications of healthcare providers who apply for participation with the organization.

Participating providers sign contracts with the insurance companies they wish to participate with and agree to accept the fee schedules set by the insurance company. The physician then can only bill the patient for their deductible and/or co-insurance. They cannot balance bill the patient the difference between what the company paid and what the physician billed.

BCBS was one of the first companies to use this model and other insurance companies later followed their lead. This idea is a proven way to keep costs down and assures the insurance company that their pay out fees will only go up if the negotiated contract allows for that. If a provider is not satisfied with the fee schedule, he or she may renegotiate the contracted fee schedule.

Preferred providers allow for another cost control measure. The contracts entered into by the preferred providers in the network are tighter. The preferred provider accepts approximately 10 percent less on a fee schedule than the participating provider, and the contract is handled much like that of a managed care policy. The preferred provider accepts exactly what the insurance pays and can only charge the coinsurance to the patient.

BILLING TIP

Notify the front desk employees and employees scheduling patient visits of the insurance plans that a provider does or does not accept.

Provider Manuals

Policies for BCBS carriers will vary from state to state and plan to plan. Information vital to providers is often found in the provider manual. Although the information found in each manual may vary, most will contain:

- Contact numbers for benefits, claims inquiry, customer support, etc.
- Information on identification cards including examples of identification cards and how to read them for each product offered by BCBS
- Eligibility inquiry options
- Prior authorization and medical review policy guidelines
- Coding instructions (for example, application of modifiers)
- Claims completion information and timely filing deadlines
- Some BCBS carriers will require the provider to have a login and password to access the provider manual and other online tools

BILLING TIP

Provider manuals are typically electronic and located on the BCBS carrier's website. Take time to locate and bookmark the provider manual for the BCBS carrier with which your provider is contracted.

Section Review 12.1

1. Which of the following defines Point-of-Service coverage?

   A. Coverage that requires a patient to first see their PCP
   B. Coverage that allows members to choose medical services only within the BCBS network
   C. Coverage that allows members to choose medical services as needed within the BCBS network or seek medical care outside of the network
   D. Coverage that reimburses employees for specific healthcare expenses

2. An indemnity plan is also referred to as _____.

   A. Fee-for-Service
   B. Self-pay
   C. Health Savings account
   D. Preferred Provider Organization

3. When a provider signs a contract to be a participating provider with an insurance payer they are agreeing to:

   A. Only see patients that are enrolled with that insurance company
   B. Bill the patient for the total amount the insurance company does not pay
   C. Accept the fee schedules set by the insurance company
   D. All of the above

4. Which of the following is an account that is usually funded by the employee only and reimburses employees for specified expenses as they are incurred?

   A. HRA
   B. HSA
   C. FSA
   D. HMO

5. Which type of insurance plan is a federal and state program that provides coverage to the low-income population?

   A. Medicare
   B. HMO
   C. Medicaid
   D. PPO

Claims Filing Requirements

Timely filing of claims is a time frame outlined in the Provider Participation Agreement. This requirement states that a claim needs to be submitted to the insurance payer within a specified amount of time. Each insurance company sets their own timely filing limits. It can also vary by different insurance plans within the same company.

Claims filing requirements differ between the different BCBS plans. Unless otherwise specified in the contract, the timely filing limit for BCBS plans is one year from the date of service. Others require the claim be filed by December 31 of the calendar year, following the year in which the services were rendered. Some plans require the claim to be submitted within 180 days of providing the service, while other plans may have shorter filing limitations depending on their individual benefit structure or state legal requirements.

EXAMPLE

BCBS North Carolina (NC) Federal Employee Program (FEP) requires claims to be filed by December 31 of the calendar year while BCBS NC BlueCard claims must be filed within 180 days of the date of service according to the policies stated below from the BCBS NC Provider eManual.

Timely Filing Requirements (FEP)

Providers participating with BCBSNC are required to file FEP claims by December 31 of the calendar year, following the year in which the services were rendered or the date of discharge. Corrected claims must be submitted within (3) years/thirty-six (36) months from the date the original claim was processed by Blue Cross NC.

Timely Filing

Claims for professional services provided to BlueCard® members having coverage with other Blue Plans (non-BCBSNC) must be submitted to BCBSNC within 180 days of providing service. Institutional/facility claims must be filed within 180 days of the member's discharge date.

Source: https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/BlueBook_Feb2018.pdf

Review the provider manuals concerning the timely filing requirement for each of the BCBS plans in which providers participate.

When a claim is denied because it was filed past the timely filing deadline, it may need to be appealed. Many BCBS carriers give a list of what they consider proof of timely filing. For example, BCBS of Texas will accept the following as proof of timely filing for HMO Blue Texas and Blue Advantage HMO:

- Texas Department of Insurance (TDI) Mail Log
- Certified Mail Receipt (only if accompanied by TDI mail log)
- Availability Electronic Batch Response (EBR) Reports
- Above documentation indicating that the claim was filed with the wrong division of BCBS of Texas
- Documentation from Blue Essentials, Blue Advantage HMO, or Blue Premier indicating the claim was incomplete
- Documentation from Blue Essentials, Blue Advantage HMO, or Blue Premier requesting additional information
- Primary carrier's EOB indicating claim was filed with primary carrier within the timely filing deadline

Source: http://www.bcbstx.com/provider/pdf/secf_filing_claims.pdf

Explanation of Benefits (EOB)

To explain the status of a claim, Blue Cross Blue Shield sends an Explanation of Benefits (EOB) to their covered members, and a Remittance Advice (RA) to providers after they or other covered family members receive healthcare services. BCBS encourages the use of electronic funds transfer (EFT) and electronic remittance advice (ERA).

The EOB will include the following information:

- Identifying information for all parties including the patient, medical provider, and insurance payer
- Claim total
- Adjustments applied to the submitted claim
- Amount paid
- Claim status such as paid, denied, pending
- Explanation of decision

Below is an example of an Explanation of Benefits (EOB):

Blue Cross Blue Shield

Explanation of Benefits (EOB). **This is not a bill.**

JOHN DOE
8976 MAIN STREET
ANYWHERE, UT 12345

Claim Information

Member Name: John Doe
Group No.: 56789
Identification No.: ABC123456789
Claim No.: 20140000000000X
Patient Name: John Doe

Summary

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered
ABC Physician Group				
Office Visit, Level III	07-09-20XX	$75.00	$6.00	$69.00
Totals		**$75.00**	**$6.00**	**$69.00**

Coverage Information

Totals	**$75.00**	**$6.00**	**$69.00**
PARTICIPATING PROVIDER (REDUCTION)		$6.00	
Deductions			
Your PCP Copayment Amount		$15.00	
Total Deductions			**-$15.00**
Total Benefits Approved			**$54.00**
Amount You May Owe Provider			**$15.00**
Total covered benefits approved for this claim $54.00 to ABC Physician Group on 07-21-20XX.			

RAs will vary from carrier to carrier and plan to plan but will contain most of the same information.

Common Denials

Blue Cross Blue Shield common denials include billing and data entry errors, non-compliance with coverage policy, and billing for services not medically necessary.

Billing/data entry errors include:

- **Incorrect member alpha-prefix and ID number or member not covered**—Eligibility should be checked at each visit. Obtain a copy of the insurance card and verify the three-character alpha prefix. This prefix is key to identifying and correctly routing out-of-state claims to the appropriate BCBS plan. One provider may see a common three-character prefix for that area; do not assume this is the correct three-character prefix for all BCBS members.
- **Duplicate claim**—Claims should only be sent once unless the carrier did not receive the claim, or the claim is corrected. Automatically resubmitting claims that have not been paid or denied slows down the claims payment process and creates confusion for the member who will receive multiple EOBs. Claims are commonly denied as duplicate claims because of improperly submitting corrected claims. Follow the guidance from your local BCBS carrier to submit corrected claims. For example, BCBS of Texas requires the use of the Claim Inquiry Resolution (CIR) tool.
- **Invalid/missing diagnosis code or procedure code**—When a diagnosis or procedure code is missing or invalid, the claim may be denied with one of the following reasons:
  - This service is not covered when performed with an invalid diagnosis code.
  - This principal diagnosis code is invalid. The provider must submit a valid code.
  - This diagnosis code or procedure code is not valid for the date of service on the claim.
  - A diagnosis code(s), which meets medical necessity for the procedure code is missing or invalid.
  - This procedure code is not valid or not valid for the service date on the claim line.
  - Verify reported procedure and diagnosis codes that indicate the highest level of specificity and are valid for the reported date of service. If necessary, correct the codes and resubmit the claim.
- **Claim filed after the timely filing limit**—Refer to the BCBS provider manual for the acceptable documents to prove timely filing of a claim. Billers should have a list of timely filing deadlines for their BCBS carrier, as well as all other carriers.
- **Incorrect provider number (NPI rejections)**—The NPI number of the provider and group must be registered with the local BCBS carrier. The NPI of a referring, ordering, or supervising provider is entered in item 17b; the NPI of the performing provider is entered in item 24J; the NPI of the service facility location is entered in item 32a; and the NPI of the billing provider is entered in item 33a.
- **Missing, incorrect, or invalid modifier**—When a claim is denied for the modifier, verify the use of the modifier is correct. For example, modifier 24 is only appended to E/M codes; when appended to surgical procedures, it will be denied as an invalid modifier/CPT® combination.
- **Missing or incorrect quantity billed**—The number of days or units is entered into item 24G of the CMS-1500 claim form. The number should indicate units of supplies, minutes of anesthesia, or multiple visits. The number 1 must be entered if only one service is performed.

Non-compliance with coverage policy errors:

Non-covered Service—A claim can be denied by the insurance payer if the service is not covered under the insurance plan. To prevent these denials, determine if the procedure is covered prior to the service being provided.

Prior Authorization—A prior authorization is required by insurance plans for many procedures. If the plan requires a prior authorization before performing services, and the provider failed to obtain one, the claim can be denied.

Coverage Terminated—This denial occurs when the patient does not have coverage with the insurance payer. To prevent these types of denials it is important to verify coverage prior to the provider visit.

Missing Referral—Some insurance payers require a referral from a PCP (primary care physician) for a patient to receive care from a specialist. If the patient fails to receive a referral from the PCP, the claim can be denied.

Medical necessity errors—"Not medically necessary" is when the payer has determined, based on information submitted on the claim, the service or procedure was not medically necessary. If a claim is denied due to medical necessity, the medical record should be reviewed to determine if the documented diagnosis was submitted correctly. If the diagnosis was not submitted correctly, the information needs to be corrected and the corrected claim can be resubmitted.

Insurance Representative

An Insurance Representative, also called Provider Representative or Provider Network Consultant, serves as the liaison between Blue Cross Blue Shield and the contracted provider community. The representative keeps the providers up-to-date on products, programs and initiatives, training opportunities, and contractual compliance.

BILLING TIP

Forming a good relationship with the insurance Provider Representative has many benefits. They can assist a provider if they are having billing issues, contracting issues, etc.

Appeals

Each BCBS carrier will have their own appeals process. The appeals process is typically outlined in the BCBS provider manual. For example, BCBS of NC allows a provider to request a Level I appeal to request a review of a claim regarding medical necessity, coding, bundling, fees, cosmetic services, investigational/experimental services, or certification not obtained for inpatient admissions. A Level I appeal must be submitted within 90 calendar days from the initial adjudication. Review the BCBS provider manual to determine the appeals process for your BCBS carrier.

Section Review 12.2

1. Review this Explanation of Benefits:

Service Information

Service Description	Service Date	Amount Billed	Not Covered	Covered	Pt. Responsibility
ABC Physician Group					
Office Visit, Level III	07-09-20XX	$75.00	$6.00	$69.00	$15
Totals		$75.00	$6.00	$69.00	$15

Based on the Explanation of Benefits example provided above, what is the total amount of payment the physician will receive?

A. $75.00
B. $69.00
C. $54.00
D. $15.00

2. Which of the following statements is NOT correct regarding timely filing?

A. Claims must be filed before the end of the timely filing limit.
B. Each BCBS carrier sets their own timely filing limit.
C. If the physician fails to send a claim during the timely filing limit, the balance can be sent to the patient.
D. The timely filing limit can vary from plan to plan within the same insurance company.

3. What is the timely filing requirement for Blue Cross Blue Shield?

   A. 90 days
   B. 180 days
   C. Filed by December 31
   D. Claim requirements differ between plans

4. What is the correct action when the three-character prefix is not appended to a BCBS identification number?

   A. Append the most common local prefix and file the claim.
   B. Append XXX as the prefix and file the claim.
   C. Append ZZZ as the prefix and file the claim.
   D. Look at the patient's BCBS card and append the appropriate prefix listed on the card.

5. What is the correct action when a claim has been submitted to BCBS but the provider has not received a response?

   A. Automatically refile the claim.
   B. Check claim status with the local BCBS carrier.
   C. Write off the balance.
   D. Transfer the charges to patient responsibility.

Glossary

Copay—A copayment is the amount the member pays the healthcare provider on the day of service.

Credentialing—Credentialing is the process where an insurance payer reviews and validates the professional qualifications of healthcare providers who apply for participation with the organization.

Explanation of Benefits (EOB)—Explanation of Benefits is a correspondence sent to an insurance company's covered members after they or other family members receive healthcare services.

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Member Card—Member card is a card that the insurance company issues to each member to carry for identification.

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Subscriber—The subscriber is the person who pays for the health insurance or whose employment makes him or her eligible for group health insurance.