# The BlueCard® Program Provider Manual

## January 1, 2022

This Manual is designed to assist you with education about BlueCard® and Inter-Plan business. As information is updated by the Blue Cross Blue Shield Association and/or Anthem Blue Cross, we will communicate this information to you via the Anthem Blue Cross website at www.anthem.com/ca or through our provider services staff. We are pleased to provide you with the tools and resources necessary to conduct business with the Blues in a more efficient and effective manner.

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# 1. Introduction: BlueCard® Program Makes Filing Claims Easy

As a participating provider of Anthem you may render services to patients who are National Account members of other Blue Cross and Blue Shield Plans, and who travel or live in your area.

This manual describes the advantages of the program, and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

# 2. What is the BlueCard Program?

## 2.1 Definition

BlueCard is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the United States and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other BCBS Plans, domestic and international, to your local BCBS Plan.

Your local BCBS Plan is your sole contact for claims payment, adjustments and issue resolution.

## 2.2 BlueCard Program Advantages to Providers

The BlueCard Program lets you conveniently submit claims for members from other BCBS Plans, including international BCBS Plans, directly to Anthem. Anthem will be your only point of contact for all of your claims-related questions.

Many other Blue Plans' members currently reside in your Anthem Plan service area and the growth in out-of-area membership continues to grow because of our partnership with you. That is why we are committed to meeting your needs and expectations. Working together, we can ensure your patients will have a positive experience at each visit.

## 2.3 Products included in BlueCard

A variety of products and claim types are eligible for delivery via BlueCard, however not all BCBS Plans offer all of these products to their members. Currently Anthem offers many products to our members and you may see members from other BCBS Plans who are enrolled in the other products:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization), including Blue High Performance Network℠ (BlueHPN)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
  - HMO claims are eligible to be processed under the BlueCard Program or through the Away From Home Care Program.
- Blue Cross Blue Shield Global® Core claims
- GeoBlue® Expat claims
- Medigap – Medicare Complementary/Supplemental
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards will not have a suitcase logo.
- Stand-alone SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These member ID cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo.
- Standalone vision
- Standalone prescription drugs

*NOTE: standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult the claim filing instructions on the back of the ID cards.*

*NOTE: definitions of the above products are available in the Glossary of Terms section of this Manual*

## 2.4 Products Excluded from the BlueCard Program

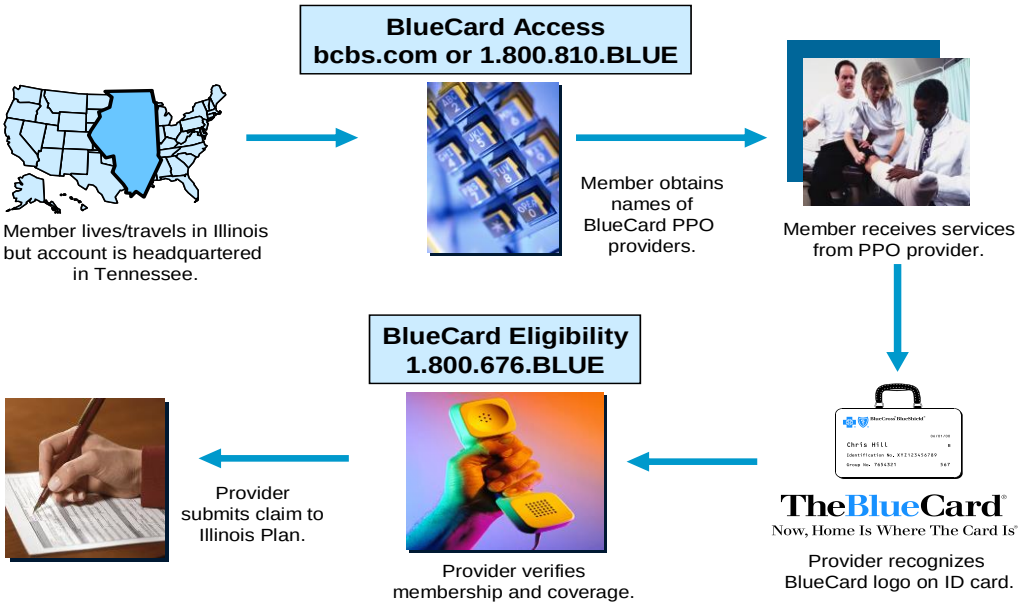
The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Vision products delivered through an intermediary model (using a vendor)
- Self-administered prescription drug products delivered through an intermediary model (using a vendor)
- Medicaid and SCHIP products that are part of a state's Medicaid program
- Medicare Advantage*
- The Federal Employee Program (FEP)

Please follow Anthem billing guidelines.

*Medicare Advantage is a separate program from BlueCard, and delivered through its own centrally administered platform. However, since you might see members of other BCBS Plans who have Medicare Advantage coverage, there is a section on Medicare Advantage claims processing in this manual.

# 3. How the BlueCard Program Works




In the example above, suppose a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another Plan's service area, in this example, Illinois:

1) If the member was traveling in Illinois, or

2) If the member resided in Illinois and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, the member can obtain the names and contact information for BlueCard PPO providers in Illinois by calling the BlueCard Access® Line at 1.800.810.BLUE (2583). The member also can obtain information on the Internet, using the National Doctor and Hospital Finder available at www.bcbs.com.

*NOTE: MEMBERS ARE NOT OBLIGATED TO IDENTIFY PARTICIPATING PROVIDERS THROUGH EITHER OF THESE METHODS BUT IT IS THEIR RESPONSIBILITY TO GO TO A PPO PROVIDER IF THEY WANT TO ACCESS PPO IN-NETWORK BENEFITS.*

When the member makes an appointment and/or sees an Illinois BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility® Line at 1.800.676.BLUE (2583). The provider also may obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue Cross and Blue Shield of Illinois.

After rendering services, the provider in Illinois files a claim locally with Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois forwards the claim to BlueCross BlueShield of Tennessee that adjudicates the claim according to the member's benefits and the provider's arrangement with the Illinois Plan.

When the claim is finalized, the Tennessee Plan issues an explanation of benefit (EOB) to the member, and the Illinois Plan issues the explanation of payment, or remittance advice, to its provider and pays the provider.

## 3.1 How to Identify Members

### 3.1.1 Member ID Cards

When members of BCBS Plans arrive at your office or facility, be sure to ask them for their current BCBS Plan membership identification card.

The main identifier for out-of-area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible EPO/PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank suitcase logo
- An HPN in a suitcase logo with the Blue High Performance Network℠ (HPN) name in the upper right or lower left corner, for BlueHPN EPO members.

Important facts concerning member IDs:

- A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the prefix.
    - Examples of prefix ID numbers:
        - ABC 1234567
        - ABC 1234H567
        - ABC 12345678901234
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the prefix.
- The prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate BCBS Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 1.800.676.BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.

- Remember that member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers.

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims between BCBS Plans. The prefix identifies the BCBS Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with claim processing.

- Do not make up prefixes.
- Do not assume that the member's ID number is the social security number. All BCBS Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.

*Sample ID Cards*



BlueCard ID cards have a suitcase logo, it may be an empty suitcase, a PPO in a suitcase or an HPN in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to your Anthem PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a BCBS Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

The BlueHPN EPO product includes an HPN in a suitcase logo on the ID card. Members must obtain services from BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for covered services in accordance with your BlueHPN contract with Anthem. If you are not a BlueHPN provider, it's important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to Anthem PPO provider contract, just like you are for other EPO products.

The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members with traditional or HMO coverage, you will be reimbursed according to Anthem traditional provider contract.

For members who have POS coverage, you will be reimbursed according to Anthem POS provider contract, if you participate in the BlueCard POS voluntary program or you will be reimbursed according to Anthem traditional provider contract, if you don't participate in the BlueCard POS voluntary program.

Some BCBS ID cards don't have any suitcase logo on them. ID cards for Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of the state's Medicaid program, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While Anthem routes all of these claims for out-of-area members to the member's BCBS Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's BCBS Plan via the established electronic crossover process.

## 3.2 How to Identify BlueCard BlueHPN Members

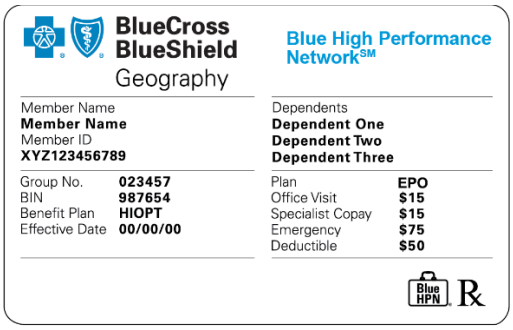
Blue High Performance Network℠ (BlueHPN℠) is a narrow network that is available to members that live in key metropolitan areas. BlueHPN members must access BlueHPN providers in order to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for services provided to BlueHPN members according to the BlueHPN contract with Anthem. If you are not a BlueHPN provider, it's important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas.

You can recognize BlueHPN members by the following:

- The Blue High Performance Network℠ name on the front of the member ID card
- The BlueHPN in a suitcase logo in the bottom right hand corner of the member ID card

Language regarding benefit limitations is also included on the back of the BlueHPN EPO member ID card. For these limited benefits, if you are not a BlueHPN provider but are a PPO provider, you will be reimbursed according to your Anthem PPO provider contract, just like you are for other EPO products.

*Sample ID Card:*



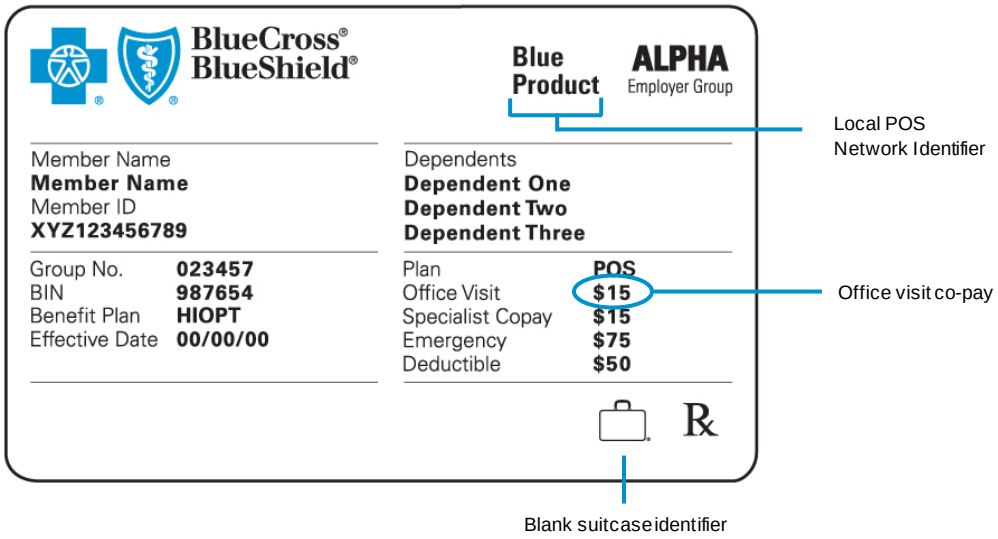

## 3.3 How to Identify BlueCard Managed Care/POS Members

The BlueCard Managed Care/POS program is for members who reside outside of their BCBS Plan's service area. Unlike the BlueCard PPO Program, in the BlueCard Managed Care/POS program, members are enrolled in Anthem's network and have a primary care physician (PCP). You can recognize BlueCard Managed Care/POS members who are enrolled in Anthem's network through the member ID card as you do for all other BlueCard members. The ID cards will include:

- The three-character prefix at the beginning the member's ID number.
- A local network identifier.
- The blank suitcase logo.

For members who participate in the BlueCard POS coverage, you will be reimbursed according to Anthem POS provider contract, if you participate in the BlueCard POS voluntary program. If you don't participate in the BlueCard POS voluntary program, you will be reimbursed according to Anthem traditional provider contract.

*Sample ID Card:*



## 3.4 How to Identify and File Claims for International Members

Occasionally, you may see identification cards that are from members of International Licensees or that are for international-based products. Currently, those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, and Blue Cross Blue Shield of Costa Rica, and those products include those provided through GeoBlue and the Blue Cross Blue Shield Global™ portfolio; however, if in doubt, always check with Anthem as the list of International Licensees and products may change. ID cards from these Licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic BCBS Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to Anthem. See below for sample ID cards for international members and products.

**Example of an ID card from an International Licensee:**

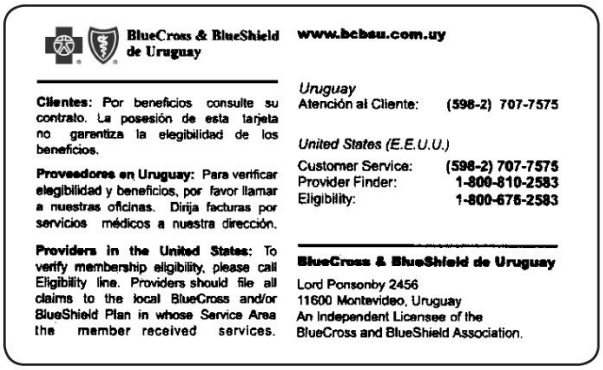

BlueCross & BlueShield de Uruguay

MEMBER NAME
Member Name
MEMBER ID
XYZ 0123456789
Plan PPO
GROUP URU038
BC/BS Plan Codes: 154/654

Plan
1400
RPA PREMIUM
Expiration Date: May. 31, 2011

CREDENCIAL PARA USO EXCLUSIVO FUERA DE URUGUAY

PPO


BlueCross & BlueShield de Uruguay

www.bcbsu.com.uy

**Clientes:** Por beneficios consulte su contrato. La posesión de esta tarjeta no garantiza la elegibilidad de los beneficios.

**Proveedores en Uruguay:** Para verificar elegibilidad y beneficios, por favor llamar a nuestras oficinas. Dirija facturas por servicios médicos a nuestra dirección.

**Providers in the United States:** To verify membership eligibility, please call Eligibility line. Providers should file all claims to the local BlueCross and/or BlueShield Plan in whose Service Area the member received services.

*Uruguay*
Atención al Cliente: (598-2) 707-7575

*United States (E.E.U.U.)*
Customer Service: (598-2) 707-7575
Provider Finder: 1-800-810-2583
Eligibility: 1-800-676-2583

**BlueCross & BlueShield de Uruguay**
Lord Ponsonby 2456
11600 Montevideo, Uruguay
An Independent Licensee of the BlueCross and BlueShield Association.

**Examples of ID cards for International Products**

Illustration A - GeoBlue:


GeoBlue

Xplorer Premier
XP-5000-NRX

Jane E
Demo
QHF999999999H

Group No. 99990483
BIN 610020
Coverage Dates 15-Apr-2016 - 14-Apr-2017

Copay in Network, Inside U.S. $30
Copay in Network, Outside U.S. $0
Copay Out of Network, Outside U.S. $10

PPO


GeoBlue

www.geobluetravelinsurance.com

**Members:** See benefit booklet for services covered by your plan. Possession of this card does not guarantee eligibility for benefits.

**Medical claims incurred Inside the U.S., Puerto Rico, and U.S. Virgin Islands**
Hospitals or Physicians: file claims with local Blue Cross and/or Blue Shield Plan
Members: See benefit booklet for claims filing procedures or visit **www.geobluetravelinsurance.com.**

**Claims incurred Outside the U.S., Puerto Rico, and U.S. Virgin Islands and all Dental and Rx claims**
File all claims with GeoBlue, Claims Department P.O. Box 1748, Southeastern, PA 19399-1748, USA.
Visit **www.geobluetravelinsurance.com** for instructions.

Medical benefits underwritten by 4 Ever Life Insurance Company, Oakbrook Terrace, IL, an independent licensee of the Blue Cross and Blue Shield Association.

Universal Rx

24/7 Member Services
Outside the U.S. +1.610.254.5850
Toll Free Within the U.S. 1.855.481.6647
customerservice@geo-blue.com

24/7 Medical Assistance Including Evacuation
Collect Calls Accepted +1.610.254.8771
globalhealth@geo-blue.com

Prescription/Pharmacy Information
Pharmacy Help Desk 1.800.788.2910

GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of the Blue Cross and Blue Shield

Pharmacy benefits administrator.

Illustration B – Blue Cross Blue Shield Global portfolio:

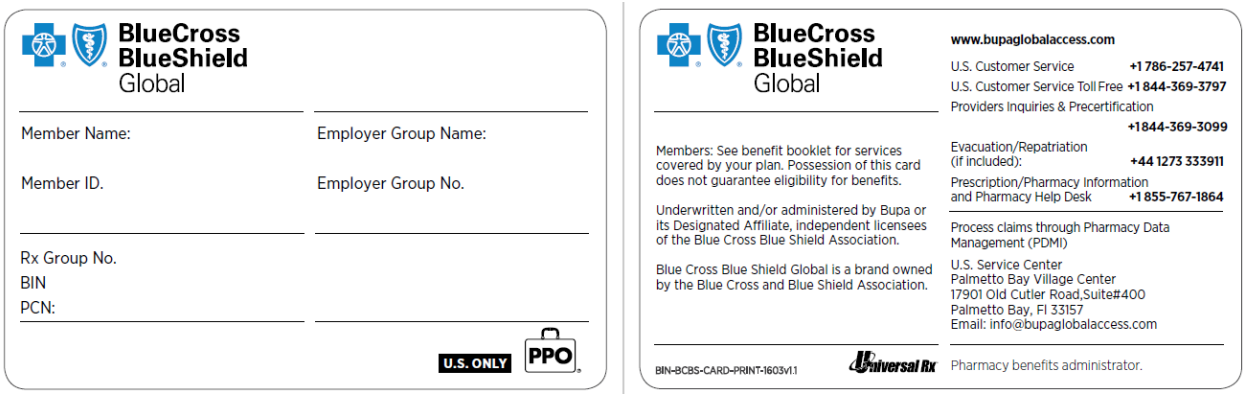
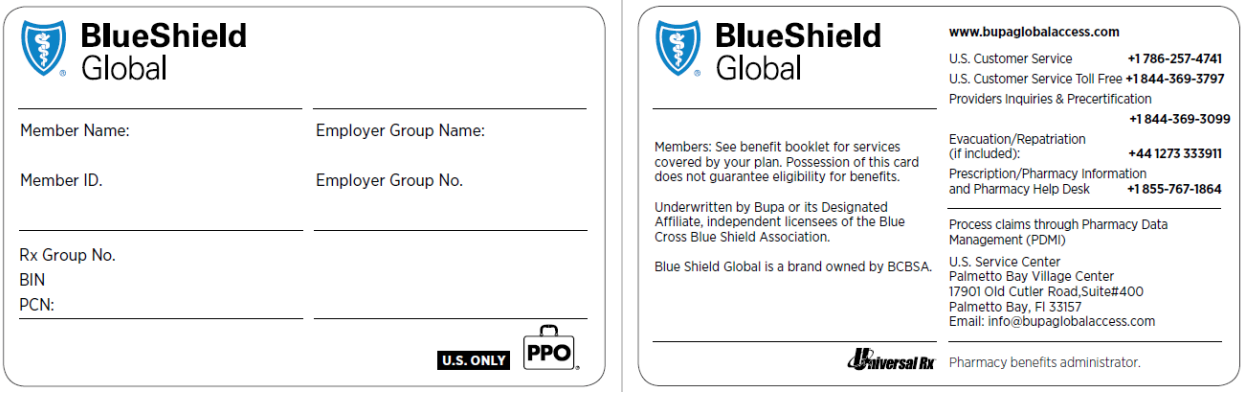



Illustration C – Shield-only ID Card:

Please note that in certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global logo (see example below):




**Canadian ID Cards**

Please note that the Canadian Association of Blue Cross plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States. You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

- Alberta Blue Cross
- Manitoba Blue Cross
- Medavie Blue Cross
- Ontario Blue Cross
- Pacific Blue Cross
- Quebec Blue Cross
- Saskatchewan Blue Cross

Source: http://www.bluecross.ca/en/contact.html

## 3.5 Consumer Directed Healthcare and Healthcare Debit Cards

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower Members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

Members who have Consumer-Directed Healthcare (CDHC) plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "standalone" debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

Reduce bad debt

Reduce paperwork for billing statements

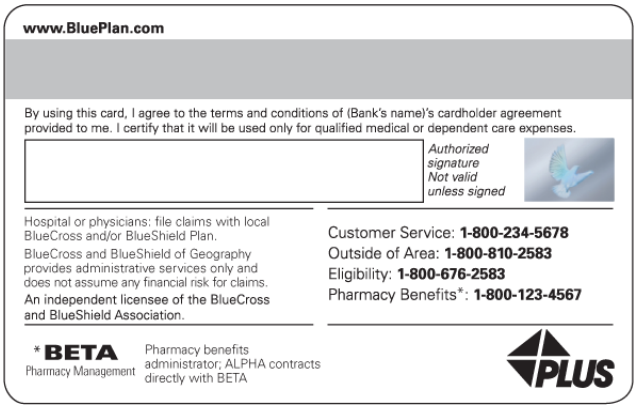
Minimize bookkeeping and patient account functions for handling cash and checks

Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

Below is a sample stand-alone healthcare debit card:


Below is a sample combined healthcare debit card and member ID card:


The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Helpful Tips:

- *Using the member's current member ID number, including three-character prefix, carefully determine the member's financial responsibility before processing payment. Check eligibility and benefits electronically by submitting a HIPAA 270 eligibility inquiry through Availity at www.availity.com or by calling 1.800.676.BLUE (2583) and providing the member ID number including the three-character prefix.*
- *All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to your local Anthem Plan for proper benefit determination, and to update the member's claim history.*
- *Please do not use the card to process full payment up front. If you have any questions about the member's benefits, please contact 1.800.676.BLUE (2583) or, for questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.*

## 3.6 Limited Benefits Products

Verifying BCBS patients' benefits and eligibility is important, now more than ever since new products and benefit types entered the market. Patients who have traditional, PPO, HMO, POS or other coverage, typically with high lifetime coverage limits i.e. ($1 million or more), may have annual benefits limited to $50,000 or less.

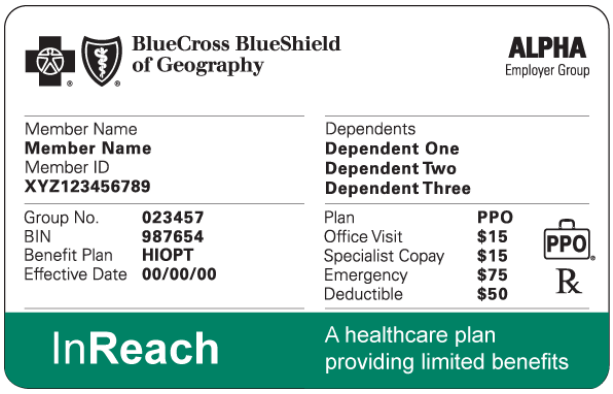
Anthem may offer such limited benefit plans to our members but you may also see patients with limited benefits who are covered by another Blue Plan.

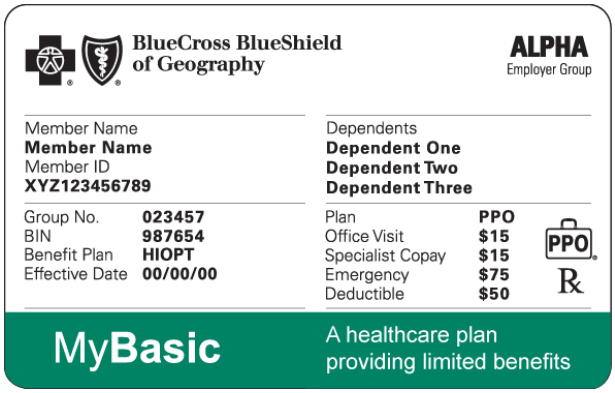
**How to recognize members with limited benefits products?**

Members with limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification cards

These ID cards may look like this:




**How to find out if the patient has limited benefit coverage?**

In addition to obtaining a copy of the patient's ID card, and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility

- You may do so electronically by submitting HIPAA 270 eligibility inquiry to Anthem, or through Availity at www.availity.com or by calling 1-800-676-BLUE for out-of-area member eligibility.
- Both electronically and via phone, you will receive patient's accumulated benefits to help you understand the remaining benefits left for the member.
- Tips: In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, always verify eligibility and benefits electronically through Availity at www.availity.com or by calling 1.800.676.BLUE (2583). You will receive the member's accumulated benefits to help you understand his/her remaining benefits.

- If the cost of service extends beyond the member's benefit coverage limit, please inform your patient of any additional liability he/she might have.
- *If you have questions regarding a BCBS Plan's limited benefits ID card/product, please contact your local Anthem Plan*
- If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

**What should I do if the patient's benefits are exhausted before the end of their treatment?**

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment are member's liability.

We recommend that you inform the patient of any potential liability they might have as soon as possible.

**Who do I contact if I have additional questions about Limited Benefit Plans?**

If you have any questions regarding any BCBS Plans' Limited Benefits products, contact your local Anthem Plan.

## 3.6.1 Reference Based Benefits

With health care costs increasing, employers are considering alternative approaches to control health care expenses by placing a greater emphasis on employee accountability by encouraging members to take a more active role while making health care decisions. Plans have begun to introduce Reference Based Benefits, which limit certain (or specific) benefits to a dollar amount that incents members to actively shop for health care for those services.
The goal of Reference Based Benefits is to have members engage in their health choices by giving them an incentive to shop for cost effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated "reference cost" ceiling for a single episode of service. Due to the possibility of increased member cost sharing, Reference Based Benefits will incent members to use Plan transparency tools, such as the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost effective providers and/or facilities that charge at or below the reference cost ceiling.

**How does Reference Based Benefits work?**
Reference Based Benefits are a new benefit feature where the Plan will pay up to a pre-determined amount for specific procedures called a "Reference Cost." If the allowed amount exceeds the reference cost, that excess amount becomes the members' responsibility.

**How are Reference Costs Established?**
The reference costs are established for an episode of care based on claims data received by Anthem from providers in your area.

**How will I get paid?**
Reference Based Benefits will not modify the current contracting amount agreed on between you and Anthem. Providers can expect to receive their contract rate on all procedures where Reference Based Benefits apply.

Example 1: If a member has a reference cost of $500 for an MRI of the spine and the allowable amount is $700, then Anthem will pay up to the $500 for the procedure and the member is responsible for the $200.
Example 2: If a member has a reference cost ceiling of $600 for a CT scan of the Head/Brain and allowable amount is $400, then Anthem will pay up to the $400 for the procedure.

**How much will the member be responsible for out-of-pocket?**
When Reference Based Benefits are applied and the cost of the services rendered is less than the reference cost ceiling, then Anthem will pay eligible benefits as it has in the past; while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, co-pay, or deductible as normal.
If the cost of the services rendered exceeds the reference cost ceiling, then Anthem will pay benefits up to that reference cost ceiling, while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, co-pay, or deductible; as well as any amount above the reference cost ceiling up to the contractual amount.

**How will I be able to identify if a member is covered under Reference Based Benefits?**
When you receive a response from a benefits and eligibility inquiry, you will be notified if a member is covered under Reference Based Benefits.
Additionally, you can call the BlueCard Eligibility number 1.800.676.BLUE (2583) to verify if a member is covered under Reference Based Benefits.

**Do I need to do anything different if a member is covered under Reference Based Benefits?**
While there are no additional steps that you need to take, you may want to verify the reference cost maximum prior to performing a procedure covered under Reference Based Benefits. You can check if Reference Based Benefits apply to professional and facility charges for the member, by submitting an electronic a benefits and eligibility inquiry to your local BCBS Plan. Alternatively, you can contact the member's Plan by calling the Blue Eligibility number 1.800.676.BLUE (2583).

**Do Reference Based Benefits apply to emergency services?**
No. Reference Based Benefits are not applicable to any service that is urgent or emergent.

**Do Reference Based Benefits apply to benefits under the Affordable Care Act essential health benefits?**
Yes. Health plans must offer products at the same actuarial value to comply with the Affordable Care Act legislative rules.

**How does the member identify services at or below the reference cost?**
Members with Reference-Based Benefits use consumer transparency tools to determine if a provider will deliver the service for less than the reference cost.

**How will the Reference Based Benefits cost apply to professional and facility charges?**
For more information on how Reference Based Benefits will apply costs to the professional and facility charges please submit an electronic benefits and eligibility inquiry to the members local BCBS Plan. If you have additional questions, you can contact the Blue Eligibility number

1.800.676.BLUE (2583) for the member you are seeing. *For Electronic Provider Access, see section 3.9.*

**What if a member covered under Reference Based Benefits asks for additional information about their benefits?**
Since members are subject to any charges above the reference cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost.
You can also direct members to view their BCBS Plan's transparency tools to learn more about the cost established for an episode of care.

**What procedures are covered under Reference Based Benefits?**
Applicable services vary by employer group but can include inpatient, outpatient, office visits, labs and diagnostic services.

**Where do I submit the claim?**
You should submit the claim to your local Anthem Plan according to your current billing practices.

**How will Reference Based Benefits be shown on a payment remittance?**
When you receive payment for services the claim will pay per the member's benefits with any amount over the reference cost being applied to the Benefit Maximum.

**Is there anything different that I need to submit with member claims?**
No. You should continue to submit your claims as you previously have to Anthem.

**Who do I contact if I have a question?**
If you have any questions regarding the Reference Based Benefits, please contact your local Anthem Plan.

## 3.7 Coverage and Eligibility Verification

For Anthem members, visit our website at www.anthem.com.

- For other Blue Plans' members, submit a HIPAA 270 eligibility inquiry through Availity at www.availity.com or call BlueCard Eligibility (1.800.676.BLUE) to verify the patient's eligibility and coverage.
  - Electronic—Submit a HIPAA 270 transaction (eligibility) to Availity.
    - You can receive real-time responses to your eligibility requests for out-of-area members 24 hours a day, 7 days a week except for scheduled maintenance.
  - Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583)
    - English and Spanish speaking phone operators are available to assist you.
    - Blue Plans are located throughout the country and may operate on a different time schedules. You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
    - The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. *See the Claim Filing section for claim filing information.*

**Eligibility and Benefits for BlueHPN EPO Members:**

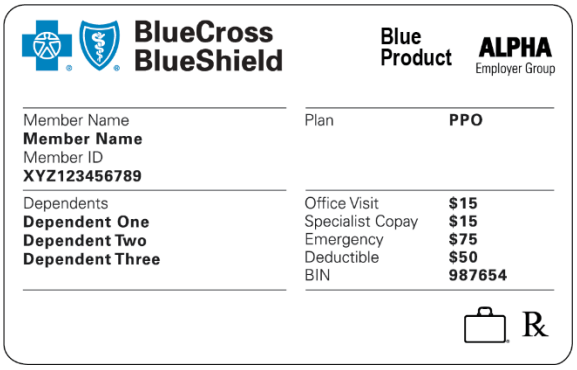
BlueHPN EPO members will be identified as such on the HIPAA 271 transaction from Anthem. If you are a BlueHPN provider, you should look for the in-network cost share on the HIPAA 271 response. If you are not a BlueHPN provider, you should be aware that the only services that are covered for BlueHPN EPO members are emergent care within BlueHPN product areas and urgent and emergent care outside of BlueHPN product areas. All other services are considered out-of-network, which will be indicated with a 100% member cost share on the HIPAA 271 transaction.

Most BlueHPN members will have the *HPN without Tiers* version of the BlueHPN product and this will be indicated on the HIPAA 271 transaction. Some members will have the *HPN with Tiers* version of the BlueHPN product and these members will have an in-network benefit and a Tier 2 benefit. For these members, Tier 2 benefits only apply to BlueHPN providers in the New Jersey and Philadelphia BlueHPN product areas. If you are a BlueHPN provider that is not located in either the New Jersey or Philadelphia BlueHPN product area, you should ignore the Tier 2 benefit on the HIPAA 271 transaction.

Electronic Health ID Cards

- Some local BCBS Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.
- Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
- An electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.

- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and PlanID.
- The PlanID data element identifies the health plan that issued the ID card. PlanID will help providers facilitate health transactions among various payers in the market place.
- Providers will need a *track 3 card reader* in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 & 2 of the magnetic stripe; tracks 1 & 2 are proprietary to the financial industry).
- Sample of electronic health ID card:




## 3.8 Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/preauthorization for out-patient services from their BCBS Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility, see section 3.10). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member's Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

General information on pre-certification/preauthorization information can be found on the out-of-area member Medical Policy and Pre-Authorization/Pre-Certification Information Router at www.anthem.com utilizing the three letter prefix found on the member ID card.

You may also contact the member's Plan on the member's behalf. You can do so by:

- For Anthem members, refer to the phone number on the back of the member's ID card.
- For other BCBS Plans members:
    - Call BlueCard Eligibility 1.800.676.BLUE (2583)—ask to be transferred to the utilization review area.
        - When pre-certification/preauthorization for a specific member is handled separately from eligibility verifications at the member's BCBS Plan, your call will be routed directly to the area that handles pre-certification/pre-authorization. You will choose from four options depending on the type of service for which you are calling:
            - Medical/Surgical
            - Behavioral Health
            - Diagnostic Imaging/Radiology
            - Durable/Home Medical Equipment (D/HME)

          If you are inquiring about both, eligibility and pre-certification/pre-authorization, through 1.800.676.BLUE (2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.
    - Submit an electronic HIPAA 278 transaction (referral/authorization) to Availity.
    - The member's BCBS Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member's BCBS Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

## 3.9 Electronic Provider Access

Electronic Provider Access (EPA) gives providers the ability to access an out-of-area member's BCBS Plan provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. EPA enables providers to use their local BCBS Plan's provider portal to gain access to an out-of-area member's BCBS Plan provider portal, through a secure routing mechanism. Once in the member's BCBS Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Plan's local providers.

The availability of EPA varies depending on the capabilities of each BCBS Plan. Some Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact BCBS Plans.

**Using the EPA Tool**

1. The first step for Anthem providers is to go to the Availity multi-payer portal at www.availity.com and log-in as you do today.
2. To access EPA functionality via the Availity portal, users must have access to "Authorization and Referral Request" and select *Authorizations* under *Authorizations and Referrals* on the left navigation menu.
3. Users then choose Anthem as the payer, choose their organization if applicable, and then enter the prefix of the member being pre-certified along with the expected date/s of service.
4. If the prefix is for an out-of-state member, users will be prompted to add their Tax ID and NPI. At that point, users will then be routed to the electronic pre-certification tool for the member's Home Plan, if available. If the Home Plan does not have electronic capabilities, then traditional phone or fax methods of pre-certification need to be utilized.

Note: You can first check whether pre-certification is required by the Home Plan by either:

1. Sending a 278 (Referral Request/Authorization Request) transaction.
2. Accessing the Home Plan's pre-certification requirements pages by using the medical policy router available on Anthem's public provider website at www.anthem.com.

Entering the member's prefix from the ID card automatically routes you to the BCBS Plan's EPA landing page. This page welcomes you to the Plan's portal and indicates that you have left Anthem's portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of Plans' pre-service review processes vary widely, Plans may include instructional documents or e-learning tools on the landing page to provide instruction on how to conduct an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The BCBS Plan landing page looks similar across Plans, but will be customized to the particular Plan based on the electronic pre-service review services they offer.

## 3.10 Provider Financial Responsibility for Pre-Service Review for BlueCard Members

Anthem participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's BCBS Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's BCBS Plan for pre-service review or for a change or modification of the pre-service review will result in in penalty reduction for inpatient facility services. The member must be held harmless and cannot be balance-billed if pre-service review has not occurred*.

Pre-service review contact information for a member's BCBS Plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available through Availity at www.availity.com. Note: the availability of EPA will vary depending on the capabilities of each member's Blue Plan
- Submitting an ANSI 278 electronic transaction to Anthem or calling 1.800.676.BLUE.

Services that deny as not medically necessary remain member liability

**Who do I contact if I have additional questions about Provider Financial Responsibility for Pre-Service Review?**

If you have any questions on Provider Financial Responsibility or general questions, please call your local Anthem Plan.

**Who do I contact if I have additional questions about Electronic Provider Access?**

If you have any questions on how to use the EPA tool, please call your local Anthem Plan.

**Unless the member signed a written consent to be billed prior to rendering the service.*

## 3.11 Updating Your Provider Information

Maintaining accurate provider information is critically important to ensure that consumers have timely access to care. Updated information helps us maintain accurate provider directories and also ensures that providers are more easily accessible to members. Additionally, Plans are required by Centers for Medicare & Medicaid Services (CMS) to include accurate information in provider directories for certain key provider data elements and accuracy of directories are routinely reviewed/audited by CMS.

Since it is the responsibility of each provider to inform Plans when there are changes, providers are reminded to notify Anthem of any changes to their demographic information or other key pieces of information, such as a change in their ability to accept new patients, street address, phone number or any other change that affects patient access to care. For Anthem to remain compliant with federal and state requirements, changes must be communicated timely so that members have

access to the most current information in the Provider Directory. Please refer to your Anthem Provider Manual or Agreement for notification requirements.

### Key Data Elements

The data elements required by CMS and crucial for member access to care are as follows:

- Physician Name
- Location (i.e. Address, Suite, City/State, Zip Code)
- Phone Number
- Specialties
- Digital contract information, including email and website address
- Accepting New Patient Status
- Hospital Affiliations
- Medical Group Affiliations

Plans are also encouraged (and in some cases required by certain regulatory/accrediting entities) to include accurate information for the following provider data elements:

- Physician Gender
- Languages Spoken
- Office Hours
- 
- Physical Disabilities Accommodations (e.g., wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, other accessible equipment)
- Indian Health Service Status
- Licensing information (i.e. Medical License Number, License State, National Provider Identifier NPI)
- Provider Credentials (i.e. Board Certification, Place of Residency, Internship, Medical School, Year of Graduation)
- 
- Hospital has an emergency department, if applicable

Effective January 1, 2022, the Consolidated Appropriations Act ("CAA") requires Plans to update provider directory information within 2 (two) business days of receiving the information from the Provider for the following data elements:

- Provider Name
- Provider Address
- Provider Telephone Number

- Provider Specialties
- Digital contact information, including email or website address

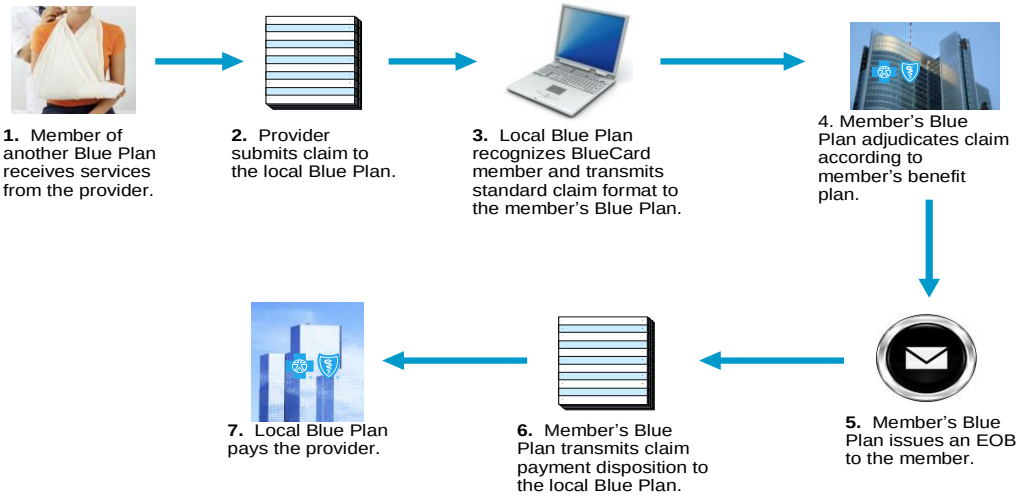
## How to Update Your Information

You should routinely check your current practice information by going to Anthem.com and selecting “Find a doctor”. If your information is not correct and updates are needed, please provide the correct information as soon as possible. Please refer to your Anthem Provider Manual on how to submit changes.

# 4. Claim Filing

## 4.1 How Claims Flow through BlueCard

Below is an example of how claims flow through BlueCard




After the member of another BCBS Plan receives services from you, you should file the claim with Anthem. We will work with the member's Plan to process the claim and the member's Plan will send an explanation of benefit, or EOB, to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the members benefits and coverage.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including prefix) and avoid unnecessary claims payment delays.
  - Check eligibility and benefits electronically by submitting a HIPAA 270 eligibility inquiry to through Availity at www.availity.com or by calling 1.800.676.BLUE (2583). Be sure to provide the member's three-character prefix.
  - Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront.
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=**F5** patient paid amount; on the CMS1500 locator **29** amount paid; on UB92 locator **54** prior payment; on UB04 locator **53** prior payment.)

- Submit all BCBS claims to your local Anthem Plan. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.
- In cases where there is more than one payer and a BCBS Plan is a primary payer, submit Other Party Liability (OPL) information with the BCBS claim. Upon receipt, Anthem will electronically route the claim to the member's BCBS Plan. The member's Plan then processes the claim and approves payment; Anthem will reimburse you for services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
  - Check claims status by submitting a HIPAA 276 claim status request through Availity at www.availity.com or by calling your local Anthem Provider Services team.

## 4.2 Medicare Advantage Claims

### 4.2.1 Medicare Advantage Overview

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

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) 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, 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.

#### Types of Medicare Advantage Plans

##### Medicare Advantage 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.

**Medicare Advantage 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.

**Medicare Advantage 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.

Blue Medicare Advantage PPO members have in-network access to Blue MA PPO providers.

**Medicare Advantage 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 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 currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with your Anthem Plan.
- 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.
- Submit your MA PFFS claims to your local Anthem Plan.

**Medicare Advantage 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.

### 4.2.2 Medicare Advantage PPO Network Sharing

**What is BCBS Medicare Advantage PPO Network Sharing?**

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

**What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?**

If you are a contracted MA PPO provider with your local Anthem Plan and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Anthem contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Anthem and you provide services for any BCBS MA 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. Other services will be reimbursed at the out-of-network benefit level.

**How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?**

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


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 Cross Blue Shield Plans?**

If you are a contracted Medicare Advantage PPO provider with Anthem, you must provide the same access to care as you do for Anthem BCBS MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

**What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?**

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

### How do I verify benefits and eligibility?

Call BlueCard Eligibility Line at 1.800.676.BLUE (2583) and provide the member's three-character prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members electronically by submitting a HIPAA 270 eligibility inquiry through Availity at www.availity.com.

### Where do I submit the claim?

You should submit the claim to your local Anthem Plan under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

### What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with Anthem, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Anthem will work with the other Plan to determine benefits and send you the payment.

### What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members', benefits will be based on the Medicare allowed amount. Once you submit the claim, Anthem will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

### May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

### What is the member cost sharing level and co-payments?

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 billed for any deductibles, co-insurance, and/or co-pays.

### What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact your local Anthem Plan.

### 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 your local Anthem Plan.

### What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted MA PPO provider. MA PPO shared networks are available in 39 states and one territory:

| | | | |
|---|---|---|---|
| Alabama | Kentucky | Nebraska | Puerto Rico |
| California | Kansas | Nevada | Rhode Island |
| Colorado | Louisiana | New Hampshire | South Carolina |
| Connecticut | Maine | New Jersey | Tennessee |
| Florida | Massachusetts | New Mexico | Texas |
| Georgia | Michigan | New York | Utah |
| Hawaii | Minnesota | Ohio | Virginia |
| Idaho | Missouri | Oklahoma | Washington |
| Illinois | Montana | Oregon | Wisconsin |
| Indiana | North Carolina | Pennsylvania | West Virginia |

### 4.2.3 Eligibility Verification

- You can verify eligibility by contacting the BlueCard Eligibility Line at 1.800.676.BLUE (2583) and provide the member's three-digit prefix located on the ID card. Be sure to ask if Medicare Advantage benefits apply.

You may also submit electronic eligibility requests for BCBS members by following three easy steps:

- Log in to Availity at www.avality.com
- Enter the required data elements
- Submit your request

If you experience difficulty obtaining eligibility information, please record the prefix and report it to Anthem. *See section 3.9, Electronic Provider Access.*

## 4.2.4 Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to your local Anthem Plan.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.
- Payment will be made directly by a Blue Plan.

## 4.2.5 Reimbursement for Medicare Advantage PPO, HMO, POS, PFFS

*Note to Provider: The reimbursement information below applies when a provider treats a Blue Cross Blue Shield Medicare Advantage member to whom the provider's contract does not apply.*

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats a Medicare Advantage HMO member.

- A provider that is contracted for commercial business only treats a MA PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats any MA PPO member.
- A provider that is contracted for local Medicare Advantage HMO business treats an out-of-area MA HMO member.
- A provider that is not contracted with the local Plan treats a MA HMO member.

Based upon 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 Cross Blue Shield 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 (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Providers that are paid on a reasonable cost basis under Original Medicare should send their CMS Interim Payment Rate letter with their Medicare Advantage claim. This letter will be needed by the Plan to calculate the Medicare Allowed amount.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

*NOTE: Enrollee payment responsibilities can include more than copayments (e.g., deductibles).*

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

**Medicare Advantage Private-Fee-For-Service (PFFS) Claim Reimbursement**

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue Cross Blue Shield Plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., 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 & Conditions under the member's Blue Plan. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

*NOTE TO PROVIDER: The reimbursement information below applies when a provider treats a Blue Cross Blue Shield Medicare Advantage member to whom the provider's contract applies.*

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats an out-of-area Medicare Advantage PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats an MA HMO member from the local Plan.

If you are a provider who accepts Medicare assignment and you render services to any Blue Cross Blue Shield Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Cross Blue Shield 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.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Cross Blue Shield Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

### 4.2.6 Medicare Advantage Coordination of Care Program

A new national Coordination of Care program to support Blue MA members was launched on January 1, 2020. The program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in your state, Anthem is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in your state and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:


**What does this new program to support Blue Medicare Advantage members mean to me?**

This program will result in some changes, including a number that will be beneficial to you, your practice and your patients. The program serves all MA PPO group members that reside in Anthem's service area, and some of the benefits that you may see include:

- You will receive consolidated information on gaps in care and risk adjustment gaps, as well as medical record requests for all Blue MA PPO members enrolled with Anthem and other Blue Plans and residing in your state through local communication practices.

- The MA PPO group members that you see may come into your practice setting more frequently for care due to Anthem's requesting care gap closures, allowing for greater continuity in care.

***Reminder:*** As outlined in your contract with Anthem, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Anthem related to this program.

**What are some of the changes that I should expect as a result of this program?**

*Medical Record Requests*

Providers will receive medical records requests from Anthem related to your patients that are MA PPO group members residing in your state and enrolled with another Blue Plan. Per the program structure, these members' Plans request medical records through Anthem. You do not need to be in contact with any Blue Plan that you are not contracted with for the purposes of medical record retrieval.

*Gap Closure Requests*

You may receive an increase in Stars and Risk Adjustment gap closure requests from Anthem for your patients that are MA PPO group members residing in your state and enrolled with another Blue Plan. Per the program structure, Stars or risk adjustment gaps for these members are communicated through the local process administered by Anthem. You do not need to be in contact with any Blue Plan that you are not contracted with for the purposes of gap closure.

In addition, this program change may result in greater contact with these members—whether it is through onsite visits or via phone outreach, and may engender better care continuity.

**HIPAA/Privacy**

Consistent with HIPAA and any other applicable laws and regulations, Anthem is contractually bound to preserve the confidentiality of health plan members' protected health information (PHI) obtained from medical records and provider engagement on Stars and/or risk adjustment gaps. You will only receive requests from the Anthem that are permissible under applicable law and, consistent with your current practices, patient-authorized information releases are not required in order for you to fulfill medical records requests and support closure of Stars and/or risk adjustment gaps received pursuant to this care coordination program.

If you have any questions regarding the applicability of HIPAA or any other privacy law or regulation to this program, please contact Anthem.

**Member Care & Administrative Reminders**

Regular reporting regarding member gaps in care are available to providers, as well as provider education on HEDIS, CAHPS and HOS via newsletters and/or provider portals.

**Annual Wellness Visits**

Annual Wellness Visits can have a direct positive impact to patient health outcomes and cost of care. These visits allow patients to be assessed in a non-acute state, allowing time to focus on the patient's individual needs and priorities for the year to support successful adherence to treatment/care plans. This approach also helps:

- ◯ Provide a structured approach to collect patient health information
- ◯ Ensure that all persistent conditions are evaluated, validated, documented, and coded to the highest level of specificity

- ◯ Establish care plans and care coordination (decrease over-/underutilization and duplication of services)
- ◯ Proactively close all gaps in care
- ◯ Assist in managing chronic conditions
- ◯ Improve patient self-management skills

### Documentation Required for Care Gap Closure

To close quality care gaps, documentation in the patient's legal medical record must be provided for each noncompliant HEDIS measure requested. The following are required elements

- Evidence that tests or services were performed, not just ordered, by the deadline established for each measure. Evidence includes date and place of service, procedure, prescription, test result or finding and practitioner type.
- Evidence of provider accountability from the practitioner or practitioner group, such as date, name and signature.

### Member Experience

The Centers for Medicare and Medicaid Services (CMS) Health Outcomes survey (HOS) gathers patient-reported health outcomes from members enrolled in Medicare Advantage plans in order to support quality improvement activities and improve the overall health of members. Increased awareness of all HOS measures can help guide provider interactions with patients and positively impact HOS results. Five of the HOS measures are included in the Medicare part C Star Ratings: improving and maintaining physical health, improving or maintaining mental health, monitoring physical activity, improving bladder control, and reducing the risk of falling. The HOS affects 10% of a plan's Star Rating. The provider's role in the HOS: ensure your patients have access to regular appointments; provide timely care and consistent follow-up; talk with Medicare Advantage-eligible patients about hard issues such as mental health status, bladder control, and physical activity; pay attention to language, literacy, or cultural barriers; ensure high-quality communication and address complaints.

The Centers for Medicare & Medicaid Services (CMS) administers the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. These patient experience surveys ask patients about how they experienced or perceived key aspects of their health care providers and plans. Focus areas include communication skills of providers, understanding medication instructions, coordination of health care needs, and ease of access to health care services. Results of the patient experience surveys are publicly reported. The health plan and the providers role in the CAHPS survey is to use the CAHPS survey results to identify areas to improve member satisfaction. This includes ensuring that members receive their annual flu vaccines; ensuring that members receive the care they need when they need it; ensuring that members receive test results quickly; and ensuring that a members care is coordinated among their personal doctor and specialists, if applicable.

### Medicare Risk Adjustment

Medicare Risk Adjustment (MRA) is a payment methodology the Centers for Medicare & Medicaid Services (CMS) uses to reimburse Medicare Advantage (MA) plans based, in part, on the health status of its members. By adjusting the premium CMS pays the MA plan based on the member's health status and demographic factors, the MRA payment model is designed to encourage MA plans to compete based on efficiencies and quality of care.

Accordingly, the goals of risk adjustment are two-fold: (i) accurate and complete documentation of diagnosis information to capture the true health status of the individual and help support appropriate patient care and management; and (ii) submission of accurate and complete diagnosis data to CMS to help ensure appropriate payment to the MA plan and providers.

**Importance of Coding Accuracy**

Providers should maintain accurate and complete medical records supporting diagnosis data submitted to the MA plan. Also, CMS requires MA plans to attest annually to the accuracy of risk adjustment data it has submitted. More specifically, CMS requires that MA plans annually certify that the risk adjustment data it submitted to CMS is "accurate, complete, and truthful based on best knowledge, information, and belief."

Accurate coding relies on complete medical record documentation. Providers are empowered to and should use their clinical judgment to diagnose and treat patients during each encounter. In doing so, providers should document each condition assessed to the highest level of specificity to accurately reflect the patient's true health status at the time of the encounter.

Complete and accurate reporting allows for a more meaningful exchange between the MA plan, member, and provider. Accurate and complete documentation and coding to the highest level of specificity, in accordance with industry coding standards (i.e., ICD-10-CM Coding Guidelines), drives an accurate clinical profile for the member and supports a framework for appropriate care planning and treatment based on the member's true health status.

## 4.3 Health Insurance Marketplaces *(aka Exchanges)*

### 4.3.1 Health Insurance Marketplaces Overview

The Patient Protection and Affordable Care Act (ACA) of 2010 provides for the establishment of Health Insurance Marketplaces (i.e., Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage. The intent of the Marketplace is to:

- Create a competitive health insurance marketplace by offering consumers a choice of health insurance plans,
- Establish common rules regarding insurance plan offerings and pricing,
- Provide information to help consumers better understand the options available to them and,
- Allow individual and small businesses to have the purchasing power comparable to that of large businesses.

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs, and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

All states have health insurance marketplaces where consumers can compare health insurance product features, coverage, and costs. Some states have set up their own, state-based Marketplace. In other states, the U.S. Department of Health and Human Services (HHS) has established a federally-facilitated Marketplace, federally-supported Marketplace, or a state-partnership Marketplace in the state.

Blue Plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that

consumers can seamlessly enroll in individual and small business health insurance products. Information on the Marketplace can be found on the Health Insurance Marketplace page of the Anthem public provider website at www.anthem.com.

### 4.3.2 Exchange Individual Grace Period

The ACA mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. The ACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Anthem indicating that the member is in the grace period.

**Exchange Individual Grace Period – Post Service Notification Letter to Provider**

Communication to providers will include the following information:

**1. Notice-unique identification number (claim includes member information):**

Claim #: _____

**2. Name of the QHP and affiliated issuer (Home Plan name)**

**3. Explanation of the three month grace period:**

Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not dis-enroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

**4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:**

Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.

**5. Consequences:**

If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

**6. QHP customer service telephone number:**

Please feel free to contact [Host Plan Name] Monday through Friday, at [enter number] if you have any questions regarding this claim.

### 4.3.3 SHOP Grace Period

Federally-facilitated SHOP requires a 31 day grace period for employers to make their full monthly payment, unless a state's regulation requires a longer period. Similar to the individual grace period, upon receipt of a claim filed during the SHOP grace period, Blue Plans may pay the claim or may pend the claim, then adjudicate the claim to pay or deny once the grace period ends or the employer pays the premium.

### 4.3.4 Health Insurance Marketplaces Claims

**What else do I need to know?**

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Anthem for claims processing and handling such as outlined below.

- Eligibility and Benefits
- Care Management
  - Pre-Service Review
  - Medical Policy
- Claim Pricing and Processing
  - Contracting
  - Claim Filing
  - Pricing
  - Claim Processing
  - Medical Records
  - Payment
  - Customer Service

**Who do I contact if I have a question about Health Insurance Marketplaces (Exchanges)?**

If you have any questions regarding the Health Insurance Marketplaces, please contact contact Anthem at the number listed on the back of the member's identification card.

## 4.4 Medicaid Claims

Blue Plans currently administer Medicaid programs in various states across the U.S. as Managed Care Organizations (MCO), providing comprehensive Medicaid benefits to the eligible population. Because Medicaid is a state-run program, requirements vary for each state, and thus each BCBS Plan.

Medicaid members have limited out-of-state benefits, generally covering only emergent situations. In some cases, such as continuity of care, children attending college out-of-state, or a lack of specialists in the member's home state, a Medicaid member may receive care in another state, and generally the care requires prior authorization.

### 4.4.1 Identifying Medicaid Members to Determine Eligibility and Benefits

BCBS ID cards do not always indicate that a member has a Medicaid product. ID cards for Medicaid members do not include the suitcase logo that you may have seen on most ID cards, but they do include a disclaimer on the back providing information on benefit limitations. For members with such ID cards, you should obtain eligibility and benefit information and prior authorization for services using the same tools as you would for other BCBS members.

- Submit an eligibility inquiry by calling the BlueCard Eligibility Line at 1.800.676.BLUE (2583)
- Submit an eligibility inquiry through Availity.
- Obtain preservice review using the Electronic Provider Access (EPA) tool

### 4.4.2 Medicaid Reimbursement and Billing

Claims for all BCBS Medicaid members should be submitted to your local BCBS Plan. If you are contracted with your local BCBS Plan for Medicaid, your local Medicaid rates will only apply for Anthem members; they do not apply to out-of-state Medicaid members. When you see a Medicaid member from another state and submit the claim, you must accept the Medicaid fee schedule that applies in the member's home state.

Please remember that billing out-of-state Medicaid members for the amount between the Medicaid-allowed amount and charges for Medicaid-covered services is prohibited by Federal regulations (42 CFR 447.15).

If you provide services that are not covered by Medicaid to a Medicaid member, you will not be reimbursed. You may only bill a Medicaid member for services not covered by Medicaid if you have obtained written approval from the member in advance of the services being rendered.

In some circumstances, a state Medicaid program will have an applicable copayment, deductible or coinsurance applied to the member's plan. You may collect this amount from the member as applicable. Note that the coinsurance amount is based on the Medicaid fee schedule for that service.

### 4.4.3 Medicaid Billing Data Requirements

When billing for a Medicaid member, please remember to check the Medicaid website of the state where the member resides for information on Medicaid billing requirements.

Providers should always include their National Provider Identifier (NPI) on Medicaid claims, unless the provider is considered atypical. Providers should also bill using National Drug Codes (NDC) on applicable claims. These data elements and other data elements that are important to submit, when applicable, on Medicaid claims are included below.

*Applicable Medicaid claims submitted without these data elements will be denied:*

- National Drug Code
- Rendering Provider Identifier (NPI)
- Billing Provider Identifier (NPI)

*Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received:*

- Billing Provider (Second) Address Line
- Billing Provider Middle Name or Initial
- (Billing) Provider Taxonomy Code
- (Rendering) Provider Taxonomy Code
- (Service) Laboratory or Facility Postal Zone or Zip Code
- (Ambulance) Transport Distance
- (Service) Laboratory Facility Name
- (Service) Laboratory or Facility State or Province Code
- Value Code Amount
- Value Code
- Condition Code
- Occurrence Codes and Date
- Occurrence Span Codes and Dates
- Referring Provider Identifier and Identification Code Qualifier
- Ordering Provider Identifier and Identification Code Qualifier
- Attending Provider NPI
- Operating Physician NPI
- Claim or Line Note Text
- Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT))
- Service Facility Name and Location Information
- Ambulance Transport Information
- Patient Weight
- Ambulance Transport Reason Code
- Round Trip Purpose Description
- Stretcher Purpose Description

### 4.4.4 Medicaid Encounter Data Reporting

The data elements mentioned above need to be included on Medicaid claims, so that BCBS MCOs are able to comply with encounter data reporting requirements applicable in their respective state.

### 4.4.5 Provider Enrollment Requirements

Some states require that out-of-state providers enroll in their state's Medicaid program in order to be reimbursed. Some of these states may accept a provider's Medicaid enrollment in the state where they practice to fulfill this requirement.

If you are required to enroll in another state's Medicaid program, you should receive notification upon submitting an eligibility or benefit inquiry. You should enroll in that state's Medicaid program before submitting the claim. To view provider enrollment requirements for BCBS Medicaid states, please visit the state's Medicaid website.

If you submit a claim without enrolling, your Medicaid claims will be denied and you will receive the following message from Anthem regarding the Medicaid provider enrollment requirements, "The state where the member is enrolled in Medicaid requires that providers enroll in their Medicaid program before the Plan can pay the provider. To view provider enrollment requirements for the state where the member is enrolled, please view the local Anthem Medicaid Provider Manual ."

You will be required to enroll before the Medicaid claim can be processed and before you receive reimbursement.

### 4.4.6 Medicaid Questions

**How do I submit Medicaid claims?**

Medicaid claims should be submitted to your local BCBS Plan in the same manner as you submit claims for other BCBS members. You will also receive your payment in the same manner, although the payment amount will likely be different from your contracted rate, or different from the Medicaid rate in the state in which you practice.

**How do I know that I am seeing a Medicaid member?**

Members enrolled in a BCBS Medicaid product are issued BCBS ID cards. Medicaid ID cards do not always indicate that a member is enrolled in a Medicaid product. Medicaid ID cards:

- Will not include a suitcase logo.
- Will contain disclaimer language on the back of the ID card indicating benefit limitations for provider awareness, for example, "This member has limited benefits outside of their Anthem state. Providers should request eligibility/benefit information.

Providers should always submit an eligibility inquiry if the ID card has no suitcase logo and includes a disclaimer with benefit limitations, using the same tools available for BlueCard:

- BlueCard Eligibility Line
- Availity

Because ID cards will not always indicate that the member is enrolled in a Medicaid product, you should always obtain eligibility and benefit information. With an eligibility response, you should receive information on Medicaid coverage.

**What amount should I expect to receive for members that reside outside of their home state's service area?**

When billing for services rendered to an out-of-state Medicaid member, you will be reimbursed according to the member's home state Medicaid fee schedule, which may or may not be equal to what you are accustomed to receiving for the same service in your state.

**My state does not require me to include an NPI or NDC code and many of the other data elements listed above on a Medicaid claim. Why do I have to include these codes?**

Most state Medicaid programs require NPI and NDC codes and the additional data elements (when applicable) to be populated on claims submitted for Medicaid members for encounter data reporting purposes. To ensure compliance with state Medicaid requirements, providers who bill for Medicaid members should include these data elements on applicable BCBS Medicaid claims or the claims may be pended or denied.

**I do not often see Medicaid members from another state. Why must I enroll as a Medicaid provider outside of my own state when billing for some Medicaid members in other states?**

Many state Medicaid programs require providers to enroll before reimbursement may be provided by the Plan. If you do not enroll with the state where required, the claim could be denied.

**Whom do I contact if I have questions?**

If you have questions, please call Anthem.

**Exhibit 1 – Medicaid Billing Data Elements**

| Required Data Elements for Medicaid Claims<br>*NOTE: Applicable Medicaid claims submitted without these data elements will be denied.* | | | | |
|---|---|---|---|---|
| **837 Reference** | **837 Professional[1] Data Element Reference** | **837 Institutional[2] Data Element Reference** | **Professional Paper Claim Item Reference (CMS1500)[3]** | **Institutional Paper Claim Form Locator (UB04)[4]** |
| National Drug Code | Loop 2410 LIN03 | Loop 2410 LIN03 | Item Number 24 Shaded Portion | Form Locator 43 |
| Rendering Provider Identifier (NPI) | Loop 2310B NM109 unless overridden when reported in Loop 2420A NM109 ONLY when Rendering is different from Loop 2010AA Billing Provider | Loop 2310D NM109 unless overridden when reported in Loop 2420C NM109 ONLY when Rendering is different from Loop 2310A Attending Provider | Item Number 33A NPI# or Item Number 24J (Unshaded) Rendering Provider ID# | Form Locators 78-79<br>Form Locator 43 Line Level |
| Billing Provider NPI | Loop 2010AA NM109 | Loop 2010AA NM109 | Item Number 33A NPI# | Form Locator 56 |

| Other Data Elements for Medicaid Claims<br>*NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.* | | | | |
|---|---|---|---|---|
| **837 Reference** | **837 Professional[1] Data Element Reference** | **837 Institutional[2] Data Element Reference** | **Professional Paper Claim Item Reference (CMS1500)[3]** | **Institutional Paper Claim Form Locator (UB04)[4]** |
| Billing Provider (Second) Address Line | Loop 2010AA N302 | Loop 2010AA N302 | Item Number 33 Billing Provider Info & Ph # Line 2 | Form Locator 1 Line 2 |
| Billing Provider Middle Name or Initial | Loop 2010AA NM105 | Loop 2010AA NM105 | Item Number 33 Billing Provider Info & Ph # Line 1 | Form Locator 1 Line 1 |
| (Billing) Provider Taxonomy Code | Loop 2000A PRV03 | Loop 2000A PRV03 | Item Number 33B Other ID # | Form Locator 81 |
| (Rendering) Provider Taxonomy Code | Loop 2310B PRV03 unless overridden when reported in Loop 2420A PRV03 | Not applicable for institutional claim | Item Number 24I ID Qualifier # | Not applicable for institutional claim |
| (Service) Laboratory or Facility Postal Zone or Zip Code | Loop 2310C N403 unless overridden when reported in Loop 2420C N403 | Loop 2310E N403 | Item Number 32 Service Facility Location Information Line 3 | Form Locator 1 Line 3 |

| Other Data Elements for Medicaid Claims<br>*NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.* | | | | |
|---|---|---|---|---|
| **837 Reference** | **837 Professional[1] Data Element Reference** | **837 Institutional[2] Data Element Reference** | **Professional Paper Claim Item Reference (CMS1500)[3]** | **Institutional Paper Claim Form Locator (UB04)[4]** |
| (Ambulance) Transport Distance | Loop 2300 CR106 unless overridden when reported in Loop 2400 CR106 | Loop 2400 SV205 with applicable revenue code | Not reportable on 1500 form | Form Locator 42 with applicable revenue code |
| (Service) Laboratory Facility Name | Loop 2310C NM103 unless overridden when reported in Loop 2420C NM103 | Loop 2310E NM103 | Item Number 32 Service Facility Location Information Line 1 | Form Locator 1 Line 1 |
| (Service) Laboratory or Facility State or Province Code | Loop 2310C N402 unless overridden when reported in Loop 2420C N402 | Loop 2310E N402 | Item Number 32 Service Facility Location Information Line 3 | Form Locator 1 Line 3 |
| Value Code Amount | Not applicable for professional claim | Loop 2300 HI in 5th position within the composite data element (Value Information HI)<br><br>Up to 24 value codes may be reported with a corresponding amount | Not applicable for professional claim | Form Locators 39-41<br><br>Up to 12 value codes may be reported with a corresponding amount<br><br>Form Locator 81 after above are exhausted |
| Value Code | Not applicable for professional claim | Loop 2300 HI in 2nd position within the composite data element (Value Information HI)<br><br>Up to 24 value codes may be reported | Not applicable for professional claim | Form Locators 39-41<br><br>Up to 12 value codes may be reported<br><br>Form Locator 81 after above are exhausted |
| Condition Code | Loop 2300 HI in 2nd position within the composite data element (Condition Information HI)<br><br>Up to 24 condition codes may be reported | Loop 2300 HI in 2nd position within the composite data element (Condition Information HI)<br><br>Up to 24 condition codes may be reported | Item Number 10d | Form Locators 18-28<br><br>Up to 11 condition codes may be reported<br><br>Form Locator 81 after above are exhausted |

| Other Data Elements for Medicaid Claims<br>***NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.*** | | | | |
|---|---|---|---|---|
| **837 Reference** | **837 Professional[1] Data Element Reference** | **837 Institutional[2] Data Element Reference** | **Professional Paper Claim Item Reference (CMS1500)[3]** | **Institutional Paper Claim Form Locator (UB04)[4]** |
| Occurrence Codes and Dates | Not applicable for professional claim | Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Information HI)<br>Up to 24 occurrence codes and associated dates may be reported | Not applicable for professional claim | Form Locators 31-34<br>Up to 8 occurrence codes and associated dates may be reported<br>Form Locators 35-36 (FROM field) may be used when available<br>Form Locator 81 after above are exhausted |
| Occurrence Span Codes and Dates | Not applicable for professional claim | Loop 2300 HI in 2nd and 4th positions within the composite data element (Occurrence Span Information HI)<br>Up to 24 occurrence codes and associated dates may be reported | Not applicable for professional claim | Form Locators 35-36<br>Up to 4 occurrence span codes and associated dates may be reported<br>Form Locator 81 after above are exhausted |
| Referring Provider Identifier and Identification Code Qualifier | Loop 2310A NM108/09 or REF01/02 unless overridden when reported in Loop 2420F NM108/09 or REF01/02 | Loop 2310F NM108/09 or REF01/02 unless overridden when reported in Loop 2420D NM108/09 or REF01/02 | Item Number 17a Other ID# or 17b NPI # | Form Locators 78-79 |
| Ordering Provider Identifier and Identification Code Qualifier | Loop 2420E NM108/09 or REF01/02 when a different from the service line Rendering Provider | Not applicable for institutional claim | Item Number 17a Other ID# or 17b NPI # | Not applicable for institutional claim |
| Attending Provider NPI | Not applicable for professional claim | Loop 2310A NM109 | Not applicable for professional claim | Form Locator 76 Line 1 |

| Other Data Elements for Medicaid Claims<br>***NOTE: Applicable Medicaid claims submitted without these data elements may be pended or denied until the required information is received.*** | | | | |
|---|---|---|---|---|
| **837 Reference** | **837 Professional[1] Data Element Reference** | **837 Institutional[2] Data Element Reference** | **Professional Paper Claim Item Reference (CMS1500)[3]** | **Institutional Paper Claim Form Locator (UB04)[4]** |
| Operating Physician NPI | Not applicable for professional claim | Loop 2310B NM109 unless overridden when reported in Loop 2420A NM108/09 | Not applicable for professional claim | Form Locator 77 Line 1 |
| Claim or Line Note Text | Loop 2300 NTE02 unless overridden when reported in Loop 2400 NTE02 (Line Note NTE) | Loop 2300 NTE02 | Item Number 19 Additional Claim Information | Form Locator 80 |
| Certification Condition Applies Indicator and Condition Indicator (Early and Periodic screening diagnosis and treatment (EPSDT) ) | Loop 2300 CRC02, CRC03 (EPSDT Referral CRC)<br>Loop 2300 CRC04 and CRC05 are used when additional conditions apply | Loop 2300 CRC02, CRC03 (EPSDT Referral CRC)<br>Loop 2300 CRC04 and CRC05 are used when additional conditions apply | Item Number 24H EPSDT/Family Plan | Form Locators 18-28 |
| Service Facility Name and Location Information | Not applicable for professional claim | Loop 2310E | Not applicable for professional claim | Form Locator 1 |
| Ambulance Transport Information<br>Patient Weight<br>Ambulance Transport Reason Code<br>Round Trip Purpose Description<br>Stretcher Purpose Description | Loop 2300<br>CR102<br>CR104<br>CR109<br>CR110 | Not applicable for institutional claim | Not reportable on 1500 form | Not applicable for institutional claim |

## Endnotes

[1] ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222, Type 1 Errata to Health Care Claim: Professional (837), June 2010, ASC X12N/005010X222A1 and Errata to Health Care Claim: Professional (837), January 2009, ASC X12N/005010X222E1.

[2] ASC X12 Standards for Electronic Data Interchange Technical Report Type 3—Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, Type 1 Errata to Health Care Claim: Institutional (837), October 2007, ASC X12N/005010X223A1, Type 1 Errata to Health Care Claim: Institutional (837), June 2010, ASC X12N/005010X223A2 and Errata to Health Care Claim: Institutional (837), January 2009, ASC X12N/005010X223E1.

[3] National Uniform Claim Committee (NUCC). 1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12. Version 2.0. July 2014.

[4] National Uniform Billing Committee (NUBC). Official UB-04 Data Specifications Manual 2015. Version 9.00. July 2014.

## 4.5 Claims Coding

Code claims as you would for Anthem claims.

## 4.6 Ancillary Claims

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  - File to the BCBS Plan in whose service area the referring provider is located.

- Durable/Home Medical Equipment and Supplies (D/HME)
  - File to the Plan in whose service area the equipment was shipped to or purchased at a retail store.

- Specialty Pharmacy
  - File to the Plan in whose service area the ordering physician is located.

*If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

| Provider Type | How to File (Required Fields) | Where to File | Example |
|---|---|---|---|
| **Independent Clinical Laboratory** (any type of non-hospital based laboratory)<br><br>Types of Service include, but are not limited to: blood, urine, samples, analysis, etc. | **Referring Provider**:<br>– Field 17B on CMS 1500 Health Insurance Claim Form or<br>– Loop 2310A (claim level) on the 837 Professional Electronic | File the claim to the Plan in whose service area the ***referring provider is located***.<br><br>**Note**:<br>• Claim must be processed based on information submitted on the claim.<br>• The referring provider NPI, as submitted on the claim, must be used to determine | Blood is drawn in lab or office setting at the request of a referring provider located in **[enter Plan X service area].**<br><br>Blood analysis is done in **[enter Plan Y service area**].<br><br>*File both portions of the claim to:* **[enter Plan X service area].** |

| Provider Type | How to File (Required Fields) | Where to File | Example |
|---|---|---|---|
| | | where service was rendered.<br>• Claims for the analysis of a lab must be filed to the Plan in whose service area the referring provider is located.<br>• BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. | |
| **Durable/Home Medical Equipment and Supplies (D/HME)**<br><br>Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc. | **Patient's Address**:<br>– Field 5 on CMS 1500 Health Insurance Claim Form or<br>– Loop 2010CA on the 837 Professional Electronic Submission.<br><br>**Ordering Provider**:<br>– Field 17B on CMS 1500 Health Insurance Claim Form or<br>– Loop 2420E (line level) on the 837 Professional Electronic Submission.<br><br>**Place of Service**:<br>– Field 24B on the CMS 1500 Health Insurance Claim Form or<br>– Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions.<br><br>**Service Facility Location Information**:<br>– Field 32 on CMS 1500 Health Insurance Form or<br>– Loop 2310C (claim level) on the 837 Professional Electronic Submission. | File the claim to the Plan in whose service area the equipment was ***shipped to or purchased in a retail store.***<br><br>**Note**:<br>• Claim must be processed based on information submitted on the claim.<br>• The Place of Service code, as submitted on the claim, must be used to determine where service was rendered (e.g. member home/equivalent setting, retail, office, etc.).<br>• BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. | A. Wheelchair is purchased at a retail store in [**enter Plan Y service area**].<br><br>*File to:* [**enter Plan Y service area**]<br><br>B. Wheelchair is purchased on the internet from an online retail supplier in [**enter Plan X service area]** and shipped to [**enter Plan Y service area].**<br><br>*File to:* [**enter Plan Y service area** ]<br><br>C. Wheelchair is purchased at a retail store in [**enter Plan X service area]** and shipped to [**enter Plan Y service area].**<br><br>*File to:* [**enter Plan Y service area** ] |
| **Specialty Pharmacy**<br><br>Types of Service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by | **Referring Provider**:<br>– Field 17B on CMS 1500 Health Insurance Claim Form or<br>– Loop 2310A (claim level) on the 837 Professional Electronic Submission. | File the claim to the Plan whose state the ***Ordering Physician is located***.<br><br>**Note**: | Patient is seen by a physician in [**enter Plan X service area**] who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in **[enter Plan Y service area**] where the member |

| Provider Type | How to File (Required Fields) | Where to File | Example |
|---|---|---|---|
| the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc. | | • Claim must be processed based on information submitted on the claim.<br>• The ordering physician NPI, as submitted on the claim, must be used to determine where service was rendered.<br>• BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. | lives for 6 months of the year.<br>*File to:* [**enter Plan X service area**] |

- The ancillary claim filing rules apply regardless of the provider's contracting status with the BCBS Plan where the claim is filed.
- Providers are encouraged to verify member Eligibility and Benefits by contacting the phone number on the back of the member ID card or call 1.800.676.BLUE (2583), prior to providing any ancillary service.

- Providers that utilize outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the risk of additional member liability for covered benefits. A list of in-network participating providers may be obtained by using Anthem's online provider directory at www.anthem.com.
  - Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
  - Providers who wish to establish Trading Partner Agreements with other Plans should contact Availity to obtain additional contact information.
  - If you have any questions about where to file your claim, please contact your local Anthem Plan.

## 4.7 Air Ambulance Claims

Claims for air ambulance services must be filed to the BCBS Plan in whose service area the point of pickup ZIP code is located.

NOTE: IF YOU CONTRACT WITH MORE THAN ONE PLAN IN A STATE FOR THE SAME PRODUCT TYPE (I.E., PPO OR TRADITIONAL), YOU MAY FILE THE CLAIM WITH EITHER PLAN.

| Service Rendered | How to File (Required Fields) | Where to File | Example |
|---|---|---|---|
| **Air Ambulance Services** | **Point of Pickup ZIP Code**:<br>– Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup<br>  – For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.<br>– Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.<br>  – Form Locators (FL) 39-41<br>  – Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.<br>  – Value: Five digit ZIP Code of the location from which the beneficiary is initially placed on board the ambulance.<br>  – For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional. | File the claim to the Plan in whose service area the point of pickup ZIP code is located*.<br><br>*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply. | • The point of pick up ZIP code is in Plan A service area.<br>• The claim must be filed to Plan A, based on the point of pickup ZIP code. |

- The air ambulance claims filing rules apply regardless of the provider's contracting status with the BCBS Plan where the claim is filed.

- Where possible, providers are encouraged to verify Member Eligibility and Benefits by contacting the phone number on the back of the Member ID card or calling 1.800.676.BLUE (2583).
- Providers are encouraged to utilize in-network participating air ambulance providers to reduce the risk of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Anthem**.**
- Members are financially liable for air ambulance services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- Providers who wish to establish Trading Partner Agreements with other Plans should contact Availity to obtain additional contact information.
- If you have any questions about where to file your claim, please contact Anthem.

## 4.8 Contiguous Counties/Overlapping Service Areas

### 4.8.1 Contiguous Counties

Claims may be filed directly to the member's BCBS Plan by contiguous area providers based on the permitted terms of the provider contact, which may include:

- Provider location (i.e. which Plan service area is the providers office located)
- Provider contract with the two contiguous counties (i.e. is the provider contracted with only one or both service areas).
- The member's BCBS Plan (i.e. is the member's BCBS Plan in a county contiguous to the provider location).
- The member's location (i.e. does the member live or work in the service area covered by his/her BCBS Plan).
- The location of where the services were received (i.e. did the member receive service from a provider located in a county contiguous to the member's BCBS Plan).
- Claims incurred in a contiguous county may be filed directly to the Control/Home Plan, solely for its members who live or work in its service area.
    - Note: Plans operating in multiple service areas are considered one service area. For example, all Anthem Plans are one service area. (e.g., when an Anthem CA member who lives or works in GA, part of the 14-state Anthem service area, receives services in AL [in a contiguous county to GA], the claim is filed directly to GA as a local GA in-network claim.) However, if the Anthem member lives or works in IL, which is not a part of the 14-state Anthem service area, the claim is filed to AL and is a BlueCard in-network claim.

### 4.8.2 Overlapping Service Areas

Submission of claims in an overlapping service area is dependent on which Plan(s) the provider contracts with in that service area, the type of contract the provider has (ex. PPO, Traditional) and the type of contract the member has with their BCBS Plan.

- If you contract with all local BCBS Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area member's claim with either Plan.
- If you have a PPO contract with one BCBS Plan, but a Traditional contract with another BCBS Plan, file the out-of-area member's claim by product type.
  - For example, if it's a PPO member, file the claim with the Plan that has your PPO contract.
- If you contract with one BCBS Plan but not the other, file all out-of-area claims with your contracted Plan.

## 4.9 Medical Records

**Medical Records**

BCBS Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other BCBS Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

**Under what circumstances may the provider get requests for medical records for out-of-area members?**

1. As part of the pre-authorization process — If you receive requests for medical records from other BCBS Plans prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Plan that requested them. This is the only circumstance where you would not submit them to Anthem.
2. As part of claim review and adjudication — these requests will come from Anthem in the form of a letter, fax, email, or electronic communication requesting specific medical records and including instructions for submission.

**BlueCard Medical Record Process for Claim Review**

1. An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
2. A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact your local Anthem BlueCard Service Center to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
3. If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact your local Anthem BlueCard Service Center to determine if the records are needed from your office.

4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

**Helpful Ways You Can Assist in Timely Processing of Medical Records**

1. If the records are requested following submission of the claim, forward all requested medical records to your local Anthem Plan at the address specified in the letter.
2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Anthem.
4. Please submit the information to Anthem as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

## 4.10 Adjustments

Contact your local Anthem Plan if an adjustment is required. We will work with the member's BCBS Plan for adjustments; however, your workflow should not be different.

## 4.11 Appeals

Appeals for all claims are handled through your local Anthem Plan. We will coordinate the appeal process with the member's BCBS Plan, if needed.

## 4.12 Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more than one health plan, and:

- Anthem or any other BCBS Plan is the primary payer, submit other carrier's name and address with the claim to Anthem. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.
- Other non-BCBS health plan is primary and Anthem or any other BCBS Plan is secondary, submit the claim to your local Anthem Plan only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's BCBS Plan will have to investigate the claim.

This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

Carefully review the payment information from all payers involved on the remittance advice (RA) before balance billing the patient for any potential liability. The information listed on the Anthem remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with Anthem.

For Professional claims if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, either "YES" or "NO" be checked. Leaving the box unmarked can cause the member's Plan to stop the claim to investigate for COB.

**Coordination of Benefits Questionnaire**

To streamline our claims processing and reduce the number of denials related to Coordination of Benefits, a Coordination of Benefits (COB) questionnaire is available to you on the Forms and Guides page of Anthem's public provider website at www.anthem.com that can assist you and your patients in avoiding potential claim issues.

When you see any Blue members and you are aware that they might have other health insurance coverage (e.g., Medicare, other commercial insurance), give a copy of the questionnaire to them during their visit. Providers should ensure that the form is completely filled out and at a minimum, includes your name and tax identification or NPI number, the policy holder's name, group number and identification number including the three character prefix and the member's signature. Once the form is complete, send it to your local BCBS Plan as soon as possible. Your local BCBS Plan will work with the member's Plan to get the COB information updated. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

## 4.13 Claim Payment

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple Explanations of Benefits (EOBs). Anthem's standard time for claims processing is less than 10 days. However, claim processing times at other Blue Plans may vary.
- If you do not receive your payment or a response regarding your payment, you can check the status of your claim by calling your local Anthem Plan, submitting a HIPAA transaction 276 claims status inquiry through Availity at www.availity.com.
- In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, Anthem may either ask you for the information or give the member's Plan permission to contact you directly.

## 4.14 Claim Status Inquiry

Anthem is your single point of contact for all claim inquiries. You can check claim status by:

- Phone—call your local Anthem Plan.

- Electronically—send a HIPAA transaction 276 through Availity at www.availity.com.

## 4.15 Calls from Members and Others with Claim Questions

If BCBS Plan members contact you, advise them to contact their BCBS Plan and refer them to their ID card for a customer service number.

The member's BCBS Plan should not contact you directly regarding claims issues. If the member's BCBS Plan contacts you directly and asks you to submit the claim to them, refer them to your local Anthem Plan.

## 4.16 Value Based Provider Arrangements

Plans have value-based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Plans.

## 4.17 Key Contacts

For additional information:

- Visit the Anthem Web site at www.anthem.com
- Contact your local Anthem Plan.

# 5. Frequently Asked Questions

## 5.1 BlueCard Basics

### 1. What Is the BlueCard Program?

BlueCard is a national program that enables members of one BCBS Plan to obtain healthcare service benefits while traveling or living in another BCBS Plan's service area. The program links participating healthcare providers with the independent BCBS Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you conveniently submit claims for patients from other BCBS Plans, domestic and international, to your local BCBS Plan.

Your local BCBS Plan is your sole contact for claims payment, adjustments and issue resolution.

### 2. What products are included in the BlueCard Program?

The following products/claims are included in the BlueCard Program:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
- Medigap
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo.
- SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo.
- Standalone vision
- Standalone prescription drugs

*NOTE: standalone vision and standalone self-administered prescription drugs programs are eligible to be processed thru BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.*

### 3. What products are excluded from the BlueCard Program?

The following products/claims are excluded from the BlueCard Program:

- Stand-alone dental
- Medicare Advantage*
- The Federal Employee Program (FEP)

Please follow your local Anthem Plan billing guidelines.

**4. What is the BlueCard Traditional Program?**

It is a national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

**5. What is the BlueCard PPO Program?**

It is a national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

**6. What is the BlueCard Managed Care/POS model?**

The BlueCard Managed Care/POS model is for members who reside outside of their BCBS Plan's service area. Under the BlueCard Managed Care/POS model, members are enrolled in Anthem network and have a primary care physician (PCP). You can recognize BlueCard Managed Care/POS members who are enrolled in Anthem's network through the member ID card as you do for all other BlueCard members.

**7. Are HMO patients serviced through the BlueCard Program?**

Yes, occasionally, Blue HMO members affiliated with other Blue Plans will seek care at your office or facility. You should handle claims for these members in the same way as for local Anthem members and Blue traditional, PPO, and POS patients from other Blue Plans by submitting claims to your local Anthem Plan.

## 5.2 Identifying members and ID Cards

**1. How do I identify members?**

When members from BCBS Plans arrive at your office or facility, be sure to ask them for their current ID card. The main identifier for out-of-area members is the prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO/EPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank suitcase logo
- An HPN in a suitcase logo with the Blue High Performance Network℠ (HPN) name in the upper right or lower left corner, for BlueHPN EPO members

**2. What is a "prefix?"**

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

### 3. What do I do if a member has an identification card without a prefix?

Some members may carry outdated identification cards that may not have a prefix. Please request a current ID card from the member.

### 4. How do I identify BlueCard Managed Care/POS members?

The BlueCard Managed Care/POS model is for members who reside outside their BCBS Plan's service area. BlueCard Managed Care/POS members are enrolled in Anthem's network and primary care physician (PCP) panels. You can recognize BlueCard Managed Care/POS members who are enrolled in Anthem's network through the member ID card as you do for all other BlueCard members.

### 5. How do I identify Medicare Advantage members?

Members will not have a standard Medicare card; instead, a BCBS 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 Medicare Advantage products will display one of the benefit product logos shown here:*** | MEDICARE ADVANTAGE \| HMO | Health Maintenance Organization |
| | MEDICARE ADVANTAGE \| MSA | Medical Savings Account |
| | MEDICARE ADVANTAGE \| PFFS | Private Fee-For-Service |
| | MEDICARE ADVANTAGE \| POS | Point of Service |
| | MA \| PPO MEDICARE ADVANTAGE | Network Sharing Preferred Provider Organization. |

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 BCBS Plan service area or region. However, when the member receives services outside his/her BCBS Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

**Anthem** participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with **Anthem.** Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

*Tip: 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.*

### 6. How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign BCBS Plan members. These ID cards will contain three-character prefixes. Please treat these members the same as domestic Blue Plan members.

**7. What do I do if a member does not have an ID card?**

Please request a current ID card from the member

## 5.3Verifying Eligibility and Coverage

**How do I verify membership and coverage?**

For local Anthem members, call the telephone number listed on the back of the member's identification card.

For other Blue Plan members, contact Anthem though Availity at www.availity.com or call BlueCard Eligibility to verify the patient's eligibility and coverage:

Electronic—Submit a HIPAA 270 transaction (eligibility) though Availity at www.availity.com.

Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583).

## 5.4 Utilization Review

**How do I obtain utilization review?**

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (*Provider Financial Responsibility). See section 3.7 Utilization Review*).

You may also contact the member's Plan on the member's behalf. You can do so by:

For Anthem members, contact your local Anthem Plan.

For other Blue Plan members,

- Phone—Call the utilization management/pre-certification number on the back of the member's card. If the utilization management number is not listed on the back of the member's card, call BlueCard Eligibility 1.800.676.BLUE (2583) and ask to be transferred to the utilization review area.
- Electronic—Submit a HIPAA 278 transaction (referral/authorization) through Availity.

*(See section 3.8, Electronic Provider Access)*

## 5.5 Claims

**1. Where and how do I submit claims?**

You should always submit claims to your local Anthem Plan. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character prefix. Do not make up prefixes. Claims with incorrect or missing prefixes and/or member identification numbers cannot be processed.

**2. How do I submit claims for international Blue members?**

The claim submission process for international BCBS Plan members is the same for domestic BCBS Plan members. You should submit the claim directly to your local Anthem Plan.

### 3. How do I handle COB claims?

If after calling 1.800.676.BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan and Anthem is the primary payer, submit the claim with information regarding COB to your local Anthem Plan.

If you do not include the COB information with the claim, the member's Blue Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

### 4. How do I handle Medicare Advantage claims?

Submit claims to your local Anthem Plan. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a BCBS Plan.

### 5. How do I handle traditional Medicare-related claims?

- When Medicare is the primary payor, submit claims to your local Medicare intermediary.
- All BCBS claims are set up to automatically cross over (or forward) to the member's BCBS Plan after being adjudicated by the Medicare intermediary.

### 6. How do I submit Medicare primary / BCBS Plan secondary claims?

- For members with Medicare primary coverage and BCBS 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 BCBS Plan name as the secondary carrier. This may be different from the local BCBS Plan. Check the member's ID card for additional verification.
- Be certain to include the prefix as part of the member identification number. The member's ID will include the prefix in the first three positions. The prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

***When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the BCBS Plan:***

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate BCBS Plan and the claim is in process. DO NOT resubmit that claim to your local Anthem Plan; duplicate claims will result in processing and payment delays.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to your local Anthem Plan with the Medicare remittance advice.
- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact your local Anthem Plan.

### 7. When will I get paid for claims?

Anthem's standard time for claims processing is less than 10 days. However, claim processing times at other Blue Plans may vary.

## 5.6 Contacts

### 1. Who do I contact with claims questions?

Your local Anthem Plan.

### 2. How do I handle calls from members and others with claims questions?

If members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number. A member's Blue Plan should not contact you directly, unless you filed a paper claim directly with that Blue Plan. If the member's Blue Plan contacts you to send another copy of the member's claim, refer the Blue Plan to your local Anthem Plan.

### 3. Where can I find more information?

For more information:

- Visit Anthem's Web site at www.anthem.com.

# 6. Glossary of BlueCard Program Terms

**Administrative Services Only (ASO)**

ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

The Anthem receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

**Affordable Care Act**

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

**bcbs.com**

The Blue Cross Blue Shield Association's Web site.

**BlueCard Access® 1.800.810.BLUE (2583)**

A toll-free 800 number for you and members to use to locate healthcare providers in another BCBS Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

**BlueCard Eligibility® 1.800.676.BLUE (2583)**

A toll-free 800 number for you to verify membership and coverage information and obtain pre-certification on patients from other BCBS Plans.

**Blue High Performance Network℠ (BlueHPN)**

A national network of providers offered in key geographies that provides national accounts enhanced quality and cost savings.

**National Doctor & Hospital Finder Website**

A website you can use to locate healthcare providers in another BCBS Plan's area http://www.bcbs.com/healthtravel/finder.html. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact your local Anthem Plan.

**Blue Cross Blue Shield Global® Core**

A medical assistance program that provides BCBS members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

**Consumer Directed Healthcare/Health Plans (CDHC/CDHP)**

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

**Coinsurance**

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

**Coordination of Benefits (COB)**

Ensures that 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 for payment.

**Co-payment**

A specified charge that a member incurs for a specified service at the time the service is rendered.

**Deductible**

A flat amount the member incurs before the insurer will make any benefit payments.

**Essential Community Providers**

Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

**Exclusive Provider Organization (EPO)**

A health benefits program in which the member receives no benefits for care obtained outside the PPO network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

**FEP**

The Federal Employee Program.

**Hold Harmless**

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with a BCBS Plan as full payment for these services.

**Marketplace/Exchange**

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a Federally-facilitated Marketplace in any state that does not do so, or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013.

**Medicaid**

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age six and low-income pregnant women. Medicaid is governed by Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

**Medicare Advantage**

The program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."
Medicare Advantage offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

**Medicare Crossover**

A program established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

**Medicare Supplemental (Medigap)**

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn't cover. Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell. Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's BCBS Plan via the Medicare Crossover process. Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

**National Account**

An employer group with employee and/or retiree locations in more than one BCBS Plan's service area.

**Other Party Liability (OPL)**

Cost containment programs that ensure that BCBS Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

**Plan**

Refers to any BCBS Plan.

**Point of Service (POS)**

A health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract.

**Preferred Provider Organization (PPO)**

A health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

**Prefix**

Three characters preceding the subscriber identification number on BCBS ID cards that identify the member's BCBS Plan or National Account.

**Qualified Health Plan (QHP)**

Under the Affordable Care Act, which started in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

**Small Business Health Options Program (SHOP)**

Program designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The program allows employers to choose the level of coverage and offer choices among health insurance plans. SHOP insurance is generally available to employers with 1-50 employees, but in some states SHOP is available to employers with 1-100 employees.

**State Children's Health Insurance Program (SCHIP)**

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

**Traditional Coverage**

Provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

# 7. BlueCard Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Plans with your local Anthem Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 1.800.676.BLUE (2583) to verify the patient's membership and coverage or submit an electronic HIPAA 270 transaction (eligibility) through Availity.
- Submit the claim to your local Anthem Plan. Always include the patient's complete identification number, which includes the three-character prefix.
- For claims inquiries, contact your local Anthem Plan.