Section 9

BlueCard and National Programs

Contents

BlueCard and National Programs – Overview

Blue Cross® Blue Shield® of Arizona (AZ Blue) network providers often render services to patients who are members of other BCBS (Blue) Plans and who travel or live in Arizona. Many of these members have individual/family plans or employer group plans that are included in the BlueCard® program. Some members have coverage through government-sponsored health plans or Medicare Advantage plans that are separate from the BlueCard program.

This section covers several different types of programs, with information about claim processing and reimbursement for members from other Blue Plans. Here's what's included:

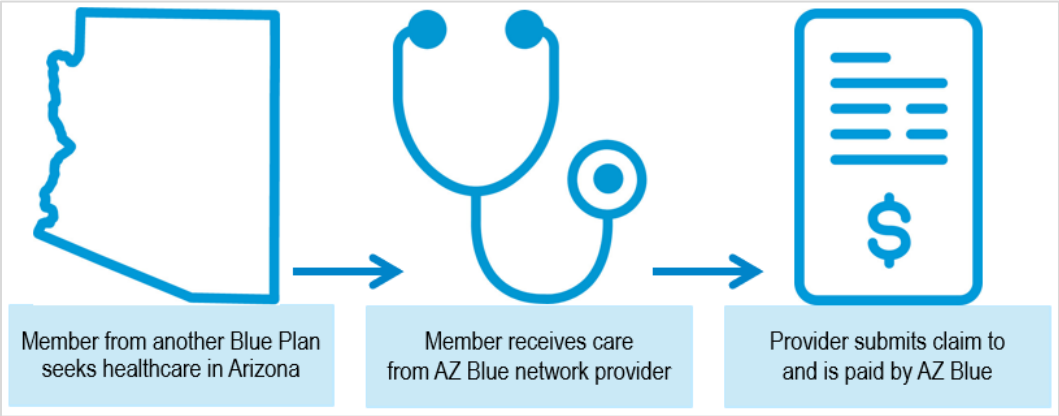
BlueCard Program

Coordinated by the Blue Cross Blue Shield Association (the "Association"), the BlueCard program makes it possible for members of a Blue Plan to access their healthcare service benefits while traveling or living outside of that plan's service area. More than 724,000 members from other Blue Plans currently reside in Arizona.

The BlueCard program links participating providers in the independent Blue Plans across the U.S., and in more than 170 countries and territories worldwide, through a single electronic network for claim processing and reimbursement.

How it works

In simple terms, this is how it works:



When a member from another Blue Plan contacts you for care, follow these steps.

1. Check eligibility and benefits as you would for an AZ Blue member.
2. Request prior authorization from the member's home Blue Plan.
3. Submit your claim to AZ Blue. We forward it to the member's home Blue Plan for adjudication. The payment information comes back to AZ Blue for provider reimbursement. For air ambulance and ancillary services, follow the specific claim filing rules in Section 19.

AZ Blue is your primary contact

AZ Blue is your primary contact for claim payment, adjustments, questions, and issue resolution. However, in certain instances (e.g., medical records requests for prior authorization, concurrent review, or disease management), the member's home Blue Plan may contact you directly.

- AZ Blue pricing and coding guidelines apply to all inpatient, outpatient, and professional BlueCard claims.
- You are reimbursed for BlueCard members' covered services at your AZ Blue-contracted rate, subject to the member's particular benefit limitations, copays, coinsurance, and deductible amounts.

BlueCard provider directory

Providers available through the BlueCard system are listed in the BCBS Find a Doctor directory. They can also be identified through the AZ Blue provider directory or by calling BlueCard at 1-800-810-BLUE (2583).

BlueCard Program

Types of plans eligible for out-of-area services

Claims for the following types of plans should always be submitted to AZ Blue, not to the member's home Blue Plan.

- PPO and EPO plans
- Traditional (indemnity insurance) plans
- HMO plans (for urgent/emergency and preauthorized follow-up care)
- Blue High Performance Network℠ (BlueHPN℠) EPO plans (see Section 8 for details)
- POS (point of service) plans
- Medicare Advantage plans
- Medicaid plans, Children's Health Insurance Program (CHIP), and Special Needs Plans (SNPs) if administered as part of a Medicaid program
- Blue Cross Blue Shield Global® Care
- International plans/benefits and international BCBS licensee plans (GeoBlue/BCBS Global, Bupa/BCBS Global, BCBS Uruguay, BCBS Panama, and Canadian Blue Cross travel products
- Stand-alone vision and prescription drug plans that *are not* delivered using a vendor

The following types of plans may be eligible for out-of-area care. However, you should follow the instructions on the back of the member ID card for claim submission.

- Federal Employee Program (FEP) plans
- Plans administered by an independent third-party administrator (TPA)
- Products delivered through a vendor
- Stand-alone dental plans

How to identify BlueCard members

The main identifier for BlueCard out-of-area members is the three-character prefix at the beginning of the member ID. You may also see the Blue Plan's logo (using the Cross and/or Shield symbols) in the upper left corner of the ID card. The member ID may have up to 17 characters, starting with the prefix. Use *all* letters and numbers in the member ID when submitting claims.

Some ID cards may not have a prefix. This could indicate that claims are handled outside the BlueCard program. Look for specific instructions or a telephone number on the back of the ID card for information about how to file claims.

For more information about ID cards, prefixes, and samples of national and international cards, see Section 10.

Eligibility and benefits

Providers can verify eligibility and benefits for out-of-area BlueCard members by using the "Eligibility & Benefits Inquiry" tool on the Availity Essentials provider portal or the AZ Blue provider portal.

Providers can also access eligibility and benefits information via HIPPA electronic transactions 270/271 (inquiry/response) – real time or batch, or by calling 1-800-676-BLUE (2583). Always use the member ID prefix from the member's ID card to be routed to the member's home Blue Plan.

BlueCard Program

Eligibility/benefit inquiry responses may indicate reference-based benefits

Some Blue Plans offer employer groups the option to include reference-based benefits in their plans. Reference-based benefits have a set dollar amount that the plan will pay for certain healthcare services not related to emergency or urgent care.

Members are held responsible for any expenses above the calculated "reference cost" for a single episode of service. Members may proactively use consumer transparency tools and check with providers to determine how much a service will cost.

Providers receive their contracted reimbursement rate on all procedures related to applicable reference-based benefits. If the cost of the services rendered exceeds the reference cost ceiling, the plan will pay benefits up to the reference cost ceiling. The member must pay standard cost-share amounts and any amount above the reference cost ceiling, up to the contractual allowed amount.

Medical policies and pre-service reviews: BlueCard routing tools

The BlueCard system offers electronic routing tools for providers to access other Blue Plans' websites to view applicable medical policies (including what is considered experimental and investigational) and conduct pre-service reviews.

You will gain access to the home Blue Plan's information about prior authorization requirements and requests, medical policies, and inpatient notification, You can access the BlueCard routing tools via the AZ Blue provider portal. For more information, see Section 11.

Claim submission

Most claims for out-of-area members (including those with Medicare Advantage plans) should be submitted to AZ Blue (EDI payer ID 53589). Here are some exceptions:

- Air ambulance and certain types of ancillary providers (labs, DME, specialty pharmacy, home infusion therapy) have different claim filing rules – see Section 19.
- When a member has both Blue plan coverage and Medicare, use the claim submission rules in Section 19 for "Blue Plan Secondary to Medicare."

Be sure to file claims using the member's ID number exactly as it appears on the ID card, including the prefix. ***The member ID prefix is essential for member identification and proper claim routing.***

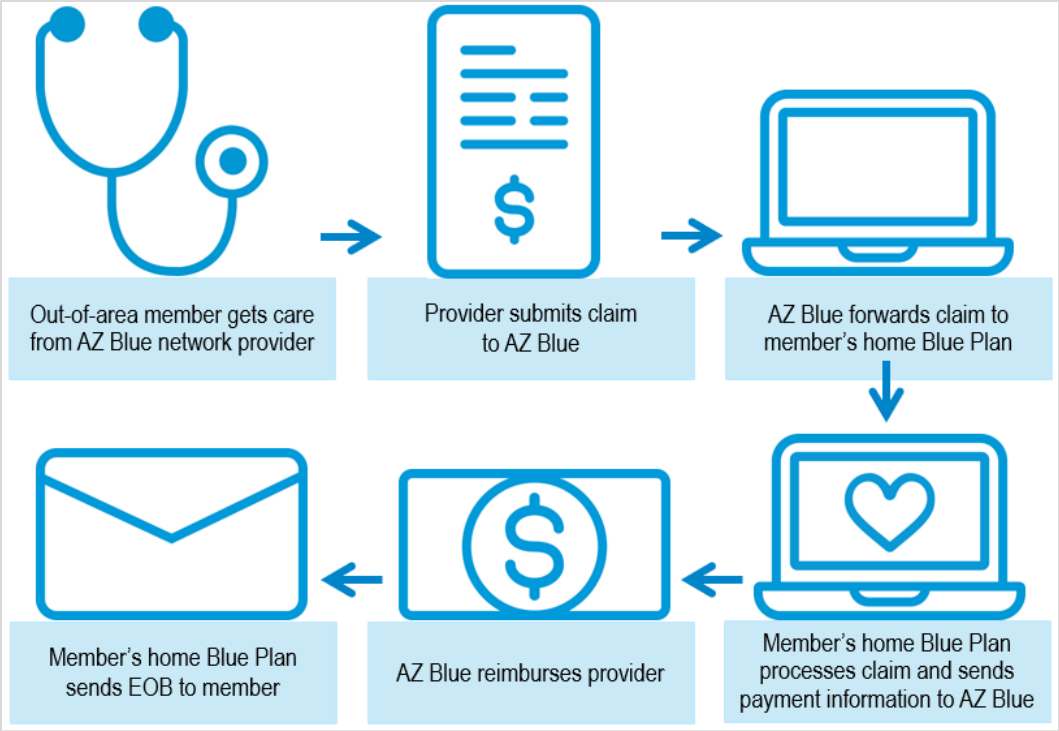
Claim processing: How it works

1. When we receive a BlueCard claim, we apply pricing and coding guidelines. We use the ClaimsXten™ coding software. For more information, see Section 18.
2. Using the member ID prefix, we then route the claim electronically to the member's home Blue Plan to determine benefits and coverage limitations, and applicable medical policies.
3. When we receive payment information from the member's home Blue Plan, we issue any payment due, and send a remittance advice to the provider. The member's home Blue Plan issues the Explanation of Benefits (EOB) to the member.

See next page for an illustration of the process.

BlueCard Program

How claims are processed:



Claim status

Providers can check BlueCard claim status via:

- HIPAA transactions 276/277 (inquiry/response) – real time or batch.
- The "Claim Status Inquiry" tool on the AZ Blue provider portal or the Availity Essentials provider portal (information includes claim number, claim receipt date, claim processed date, claim status, EFT/check number and date issued, and patient responsibility amount).
- The IVR (interactive voice response) system through BlueCard Customer Service at 602-864-4114 or 1-800-441-0483.

Medical records requests

1. **Records required for claim adjudication will be requested by AZ Blue**
   When medical records are required to adjudicate a BlueCard (out-of-area) claim, the member's home Blue Plan goes through AZ Blue to request the records. We send a notice to the provider (via fax, EMR, email, or U.S. mail) describing the requested records. Contracted providers must respond promptly, within the time frames in their provider contracts or as noted in the request notice (typically 10 business days).

   When sending records, always include the request notice: We return records submitted without a copy of the request notice because we may not forward unidentified or unsolicited medical records to other Blue Plans.

   We use the information we have on file to send records requests. If you receive a remittance advice statement indicating that records are needed and have confirmed that you did not receive a records request notice, contact AZ Blue to verify what action is required.

   We forward your records to the member's home Blue Plan within three business days. Upon receiving the medical records, the member's home Blue Plan has 30 days to make a

determination and notify AZ Blue. We monitor and track each BlueCard medical records request.

2. **Records required for prior authorization may be requested by another Blue Plan**
   As part of the prior authorization process, a member's home Blue Plan may request medical records *directly* from the provider. In this situation, the provider should transmit the records directly to that Blue Plan to expedite the review process.

Appeals and grievances

Send all BlueCard member appeals and provider grievances directly to AZ Blue. We handle any disputes related to claim coding and pricing. We forward all other disputes to the member's home Blue Plan for resolution, and you will receive decisions directly from that Plan. Member appeals and provider grievances must be in writing and include:

- A copy of the explanation of benefits
- A copy of the originally submitted claim
- A written explanation of why the action may be incorrect, and the relief requested
- Documentation that the disputed services meet medical policy requirements (clinical criteria) or pharmacy coverage guidelines
- All other documentation supporting the appeal/grievance (e.g., medical records, operative reports, office notes)

Fax this information to 602-864-5120 or mail to:

BlueCard Host Claims – Mail Stop T201
AZ Blue
P.O. Box 13466
Phoenix, AZ 85002

A provider initiating an appeal on behalf of a member should send the patient a copy of all information shared with us in connection with the appeal/grievance. If some form of member authorization is required, the member's home Blue Plan will contact you.

Note: Some member appeals and provider grievances are delegated to vendors administering certain services (e.g., eviCore for utilization management or American Specialty Health for musculoskeletal services). In this case, you must submit the appeal or grievance directly to the vendor. For more information about provider disputes and member appeals, see Sections 22 and 23.

National Accounts, CHIP, and Medicaid

National accounts

A national account is an employer group with employees (and retirees) located in more than one Blue Plan's service area. Submit claims for these members to AZ Blue using the guidelines of the BlueCard program (see page 9-4).

Children's Health Insurance Plan (CHIP) – if administered as part of Medicaid

CHIP is administered by states according to federal requirements. Coverage is available to eligible children through Medicaid and separate CHIP programs. When administered as part of Medicaid, out-of-area BCBS Medicaid/CHIP claims should be submitted to AZ Blue and will be processed under the guidelines of the BlueCard program (see page 9-4). Payment for these claims is limited to the member plan's state Medicaid reimbursement rates.

Medicaid

Medicaid members have limited out-of-area benefits, generally covering only emergency situations. In some cases (such as continuity of care, a dependent attending an out-of-state college, 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. AZ Blue network providers may choose to render services to an out-of-area Medicaid member.

Because the ID card does not always indicate that the member is enrolled in a Medicaid product, it's important to check the back of the ID card for a disclaimer about out-of-area benefit limitations. Check eligibility, benefits, and prior authorization information as you would for any other BlueCard member.

Note: For Arizona Medicaid members, providers participating with BCBSAZ Health Choice should continue to follow all guidelines in the Health Choice Provider Manual.

Medicaid claims

Submit claims for non-Arizona (out-of-area) Medicaid members to AZ Blue. National and state Medicaid claim rules/edits apply. A national drug code (NDC) is required on applicable claims. Claims without the required information will be returned.

Medicaid reimbursement

If you choose to render services to an out-of-area Medicaid member, you must accept the Medicaid fee schedule that applies in the member's home state. Federal regulations specifically prohibit billing out-of-area Medicaid members for the difference between the Medicaid-allowed amount and the billed charge amount for Medicaid-covered services.

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 before the services are rendered.

Some states require out-of-state providers to enroll in their specific Medicaid program in order to be reimbursed. Certain states will accept an AZ Blue network provider's Arizona Medicaid enrollment to fulfill this requirement. To view provider enrollment requirements for BCBS Medicaid states, visit our Provider Guides and E-learning page > Medicaid Provider Enrollment Requirements (by State).

For services rendered to Arizona Medicaid members, providers participating with BCBSAZ Health Choice will continue to be reimbursed according to their Health Choice participation agreement.

Medicare Advantage

At the national level (for BCBS out-of-area members), Medicare Advantage (MA) is a separate program from BlueCard and is coordinated through a centrally administered BCBS Association platform. However, you should still submit claims for BCBS out-of-area MA members to AZ Blue.

Summary

MA is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as "traditional" or "original" Medicare). MA offers Medicare beneficiaries several product options, including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS), and private fee-for-service (PFFS) plans.

- CMS has authorized some Blue Plans to offer MA products. In these instances, the member's home Blue Plan is the primary payer for the MA claims, not CMS. MA organizations may also offer a special needs plan (SNP).
- Based on CMS regulations, if a provider accepts Medicare assignment and renders covered services to a MA member from another Blue Plan, reimbursement will be the equivalent of the current Medicare allowable amount for all covered services. This amount may be less than the provider's billed charges. See exception below for providers contracted to participate in the AZ Blue MA BlueJourney PPO network.
- All CMS billing guidelines and claim data elements for traditional Medicare apply for MA claim submission.

Eligibility and benefits for out-of-area BCBS MA members

Eligibility and benefits can be verified via:

- HIPAA electronic transactions 270/271 (inquiry-response) – real time or batch
- The eligibility and benefits tool on the Availity Essentials provider portal or the AZ Blue provider portal
- BlueCard eligibility and benefits information at 1-800-676-BLUE (2583). Use the prefix from the member's ID card to be connected to the member's home Blue Plan.

Out-of-area MA ID cards

BCBS MA members have a member ID card with a Blue Cross Blue Shield logo and one of the following MA product logos:

When a member is living or traveling outside of the issuing Blue Plan's service area, provider reimbursement for covered services is based on the Medicare allowed amount. See exception below for MA PPO network sharing. For more information and sample ID cards, see Section 10.

MA PPO network sharing

Blue Plans approved to offer MA PPO benefit plans participate in reciprocal network sharing. This network sharing arrangement 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.

- Providers participating in the AZ Blue BlueJourney PPO network are considered in-network for out-of-area MA PPO members. Reimbursement for covered services will be in accordance with your contractual rate for the BlueJourney PPO network.

Medicare Advantage

- Providers not contracted for the BlueJourney PPO network will be considered out-of-network for out-of-area MA PPO members and are not required to see these members. Reimbursement for covered services will be the Medicare allowed amount. You may not balance bill the member for the difference between the Medicare allowed amount and billed charges.

The MA PPO "suitcase" logo on bottom of the BCBS member ID card indicates that the member is covered under the MA PPO network sharing program.

Member billing

Other than the applicable member cost-share amounts, the member's home Blue Plan directly reimburses providers. Providers may collect only the applicable cost-share amounts from the member at the time of service and may not otherwise charge or balance bill the member. For more information, see Section 17.

Claim submission for out-of-area MA members

Submit claims electronically to AZ Blue for members with MA benefit plans from other Blue Plans.

Exceptions:

- Claims for hospice services must be sent directly to CMS.
- Claims related to clinical trial charges should be submitted to Original Medicare, following the CMS claim submission guidelines for these services.

Claim status inquiries

Providers can get current claim status information via:

- HIPAA transactions 276/277 (inquiry/response) – real time or batch
- The online "Claim Status Inquiry" tool on the Availity Essentials provider portal or the AZ Blue provider portal
- The IVR (interactive voice response) system through BlueCard Customer Service at 602-864-4114 or 1-800-441-0483

BlueCard and National Programs – Quick Guide

Eligibility and benefit inquiries
Get current information through:

- HIPAA electronic transactions 270/271*
- The **Eligibility/Benefits Inquiry** tool on the Availity Essentials provider portal or the AZ Blue provider portal
- Phone inquiries at 1-800-676-BLUE (2583)

Note: The member ID prefix connects your inquiry to the member's home Blue Plan. Be sure to use the member's entire ID, including all letters and numbers as displayed on the ID card.

Medical policies and prior authorization
Use the BlueCard routing tools on AZ Blue provider portal to access applicable information from the member's home Blue Plan.

Claim submission

- **Out-of-area BlueCard claims**
  Submit out-of-area BCBS claims to AZ Blue electronically (EDI payer ID 53589). Be sure to include the member ID prefix to ensure accurate claim routing and member identification.

  If the member's ID card has no member ID prefix, check the back of the card for claim filing instructions and other contact information.
- **Out-of-area Medicare Advantage and Medicaid claims**
  Submit out-of-area BCBS Medicare Advantage and Medicaid claims to AZ Blue.

Claim status inquiries
Get current claim status information by using:

- HIPAA electronic transactions 276/277 (inquiry/response) – real time or batch.
- The **Claim Status Inquiry** tool on the Availity Essentials provider portal (for best results use the HIPAA Standard search tab) or the AZ Blue provider portal. Search results include the claim receipt date, claim processed date, claim status, EFT/check number and date issued, and patient responsibility amount).
- The IVR (interactive voice response) system through BlueCard Customer Service at 602-864-4114 or 1-800-441-0483.

Electronic claim adjustments
Submit claim corrections to AZ Blue via 837 electronic adjustment requests (for more information, see Section 19).

Records requests
Follow the instructions on the records request notice and include a copy of the request with your records.

- For records related to claim processing, send the requested records to AZ Blue.
- For records related to prior authorization, you may send records directly to the member's home Blue Plan.

Appeals and grievances
Send appeals and grievances in writing to AZ Blue (fax to 602-864-5120).