



South Carolina

BlueCard[®] Program

BlueCross BlueShield of South Carolina

Disclaimer

The information included is general and in no event should be deemed as a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.



Program Overview

BlueCard Program

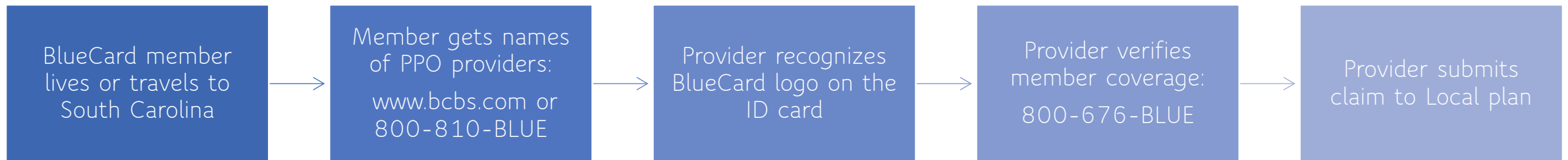
Overview

- The BlueCard program allows Blue plan members to get health care services while traveling or living in another Blue plan's service area.
- The program links participating health care providers across the country and internationally through a single, electronic network for claims processing and reimbursement.

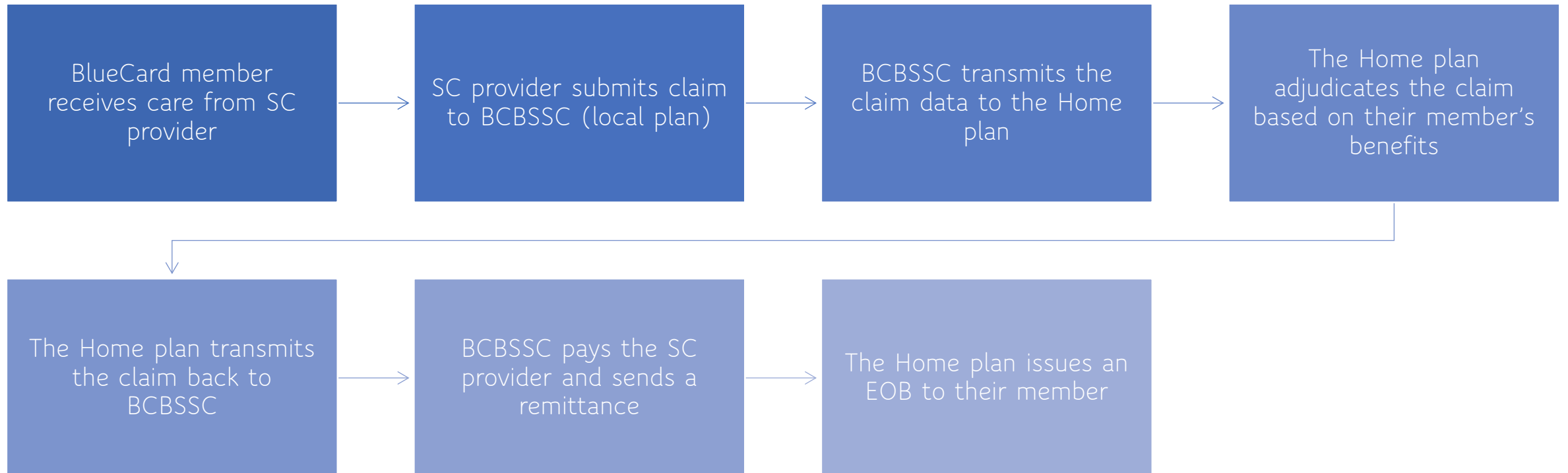
Benefits to Providers

- Let's you conveniently submit claims for members from other Blue plans directly to BlueCross BlueShield of South Carolina.
- Gives you one point of contact for all your claims-related questions.

BlueCard Eligibility and Benefits Process Flow



BlueCard Claims Process Flow





Home Plan

Home Plan General Responsibilities

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

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

Home Plan Eligibility and Benefits

- The Home plan is responsible for providing eligibility and benefits to providers.

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

Home Plan Care Management

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

The Home plan must:

Educate members about care management programs, including the member's responsibilities

Train staff in handling interactions with the Host Plan's providers

Interact with out-of-area providers in pre-service, pre-claim situations deemed as urgent, to collect clinical/medical information needed for utilization review/utilization management processes for a specific member's case

Reply to out-of-area providers' pre-service review requests within no more than 72 hours for urgent cases and 15 business days for non-urgent cases

Handle inquiries/requests and reviews from members or provider on their behalf

Coordinate member and provider on member's behalf appeals

Care Management Pre-service Review

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

Care Management Policies

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

Home Plan Medical Records

- The Home plan must request medical records only in limited circumstance (i.e., for claim adjudication).

The Home plan must:

Review criteria for requesting medical records annually.

Comply with BlueSquared medical record request requirements.

Verify if medical records are on file, or have been previously requested before sending a medical record request to the Host Plan

Send the appropriate BlueSquared Information Message when records have been previously requested on a related claim

Ensure the request is for the correct provider (e.g., referring provider versus rendering provider, in the case of a lab) and is as specific and accurate as possible

Home Plan Provider Reconsiderations

- A provider reconsideration is a one-time courtesy review offered to participating providers used to investigate the outcome of a processed claim.

The Home plan must:

Resolve member appeals and communicate outcomes to the member and/or provider

Notify the Host Plan when a member appeal is received directly from a provider

Pursue the member if an authorization is required for member appeals

Have processes in place to request and review medical records related to a claim appeal

Respond to the BlueSquared General Inquiry message (sent by the Host Plan) within 30 calendar days of receipt



Host Plan

Host Plan General Responsibilities

- The Host plan is responsible for handling all provider-related functions and interactions.

The Host plan will:

Service all providers in their service areas (including participating, nonparticipating and contracted ancillary providers)

Respond to all claim-related inquiries from their providers

Manage provider contracting and educations

Receive and price claims (including those from non-contracted providers)

Reimburse providers as appropriate

Host Plan Eligibility and Benefits

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

Host Plan Care Management

- The Home plan is responsible for supporting administration of care management.

The Host plan must:

Educate providers about how care management for out-of-area members is handled. This process may differ from what your Plan requires providers to do for local members.

Identify Host Plan care management contacts who will respond to inquiries from Home Plans

Obtain medical records, store them and transmit them appropriately to the Home Plan upon request

Actively assist providers in reporting and resolving problem cases or recurrent issues

Support providers as they assist members in complying with utilization review/utilization management requirements

Pre-service Review for Care Management

- Pre-service reviews are commonly referred to as precertification, preauthorization or prior approval.
- The Host plan must provide website access for their providers to view the Home Plans' pre-service review requirements via the Medical Policy Router and access for their local participating providers to conduct pre-service review for out-of-area members.

BlueCard Prior Authorization/Medical Policies

Need prior authorization for a patient who is a member of another Blue plan? If prior authorization is required, you can initiate the process through [My Insurance Manager](#)SM. Once you've logged in, go to Patient Care. Then select "Pre-Service Review for Out-of-Area Members" from the menu.

To view an out-of-area Blue Plan's medical policy or general prior authorization information, please select the type of information you need, enter the first three letters of the identification number on the member's Blue Cross and/or Blue Shield card, and click Submit.

Type of Information

Please select only one.

- Medical Policy
 General Precertification/Preauthorization Information

This field is required.

Alpha Prefix

This field is required.

Submit

If you experience difficulties or need additional information, please contact 800-676-BLUE.

Policies for Care Management

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

Host Plan Claim Filing and Pricing

- The Host plan must educate providers in their service area to file all claims with their local (Host) plan.
- The Host plan must accept and accurately price all claims received from participating and nonparticipating providers in their service area, in accordance with their provider contracts and Inter-Plan Programs policy requirements.
- Exceptions include:
 - Dental claims (other than services covered under medical benefits), and standalone vision and self-administered prescription drugs delivered through an intermediary model should be filed according to the instructions on the back of the ID card.
 - Medigap claims (other than services covered under medical benefits), and standalone vision and self-administered prescription drugs delivered through an intermediary model should be filed according to the instructions on the back of the ID card.

Host Plan Medical Records

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

The Host plan must:

Upon receipt of a medical record request, verify if records are already on file or have been previously requested

Be specific and not use acronyms or local jargon when requesting medical records from the provider

Ensure they are sending medical records requests to the correct provider and correct address/department within the provider's facility

Encourage their providers to respond to their requests for medical records within 10 days

Have a process in place to track open requests for medical records

Host Plan Provider Reconsiderations

The Host plan must:

Resolve provider reconsiderations and communicate outcomes to the provider

Have processes in place to promptly request medical records from providers related to a claim appeal and route them to the Home plan

Educate providers on correct filing instructions upon receipt of a BlueSquared Claim Appeal Misroute

Submit a BlueSquared General Inquiry within three business days of receipt of a provider reconsideration



Ancillary Claim Guidelines

Types of Ancillary Claims

- Durable medical equipment
 - File to the plan whose state the equipment was purchased at a retail store; or
 - File to the plan whose state the equipment was shipped
- Independent clinical laboratory
 - File to the plan where the specimen was drawn
 - The location of where the specimen was drawn is determined by the physical location of the referring provider
- Specialty pharmacy
 - File to the plan whose state the ordering physician is located



THANK YOU!