



BlueCard[®] Program

Answers to Frequently Asked Questions

What is the BlueCard Program?

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Cross and Blue Shield Plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement. You may submit claims for patients from other Blue Plans, domestic and international, to your local Blue Cross and Blue Shield Plan. The local Blue Cross and Blue Shield Plan is your sole contact for education, contracting, claims payment, adjustments and problem resolution.

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What are the roles and responsibilities of the local Blue Cross and Blue Shield Plan to their providers?

Your local Blue Cross and Blue Shield Plan's responsibilities include all provider related functions, such as:

- Being the single contact for all claims payment, customer service issues, provider education, adjustments and appeals.
- Pricing claims and applying pricing and reimbursement rules consistent with provider contractual agreements.
- Forwarding all clean claims received to the member's Blue Cross and Blue Shield Plan to adjudicate based on eligibility and contractual benefits.
- Conducting appropriate provider reviews and/or audits.
- Confirming that providers are performing services and filing claims appropriately within their scope of practice and according to their local Blue Cross and Blue Shield Plan.
- Conducting HIPAA standard transactions.
- Training for providers on BlueCard.

What are the roles and responsibilities of the member Home Plan to the provider?

- Adjudicate claims based on member eligibility and contractual benefits.
- Respond to prior authorization and pre-certification requests/inquiries.
- Request medical records through the local Plan when review for medical necessity, determination of a pre-existing condition, or high cost/utilization is required.

What are the roles and responsibilities for the provider?

- Obtaining benefits and eligibility information, including covered services, copayments and deductible requirements.
- Filing claims with the correct local Plan and including, at minimum, the required elements to ensure timely and correct processing, such as:
 - Current member ID card number
 - All Other Party Liability information
 - All member payments such as copay, coinsurance or deductibles
- Submitting medical records in a timely manner when requested by the local or member Home Plan

How can Providers obtain member eligibility information?

Member eligibility information should be obtained by submitting a Blue Exchange Eligibility & Benefits Inquiry (HIPAA transaction 270) request through your local Blue Plan, but can also be obtained by calling 1-800-676-BLUE(2583). If prior authorization or pre-certification information is required in addition to eligibility, providers should call 1-800-676-BLUE(2583).

It is more beneficial when submitting a HIPAA transaction 270 request to use the appropriate Service Type codes for the specific service being provided. Using the general Service Type "30" (Health Benefit Plan Coverage) or "1" (Medical Care) may not provide enough information to address all related inpatient, outpatient, emergency and professional benefits, and does not include information on benefit limitations and place of service requirements.

Verify the member's cost sharing amount before processing payment. Copay, coinsurance, deductibles and accumulated benefits can be obtained from the electronic Blue Exchange Eligibility & Benefits Response (HIPAA transaction 271) to the HIPAA transaction 270. Please do not process full payment upfront.

What specific information should the provider obtain?

Providers should request the most current ID card at every visit since new ID cards may be issued to members throughout the year. Member ID cards may include one of several logos identifying the type of coverage the member has and/or indicating the provider's reimbursement level.

- Blank (empty) suitcase – Traditional, HMO (Health Maintenance Organization), POS (Point of Service) and Limited Benefit Product type benefits
- PPO in suitcase – PPO (Preferred Provider Organization) or EPO (Exclusive Provider Organization) type benefits
- No suitcase – Medicaid, State Children's Health Insurance Programs (SCHIP) administered as a part of a state's Medicaid program, Medicare Complementary and Supplemental products, also known as Medigap type benefits

The provider should request specific information including eligibility, benefits, cost sharing, prior authorization/pre-certification requirements, care/utilization management requirements, and concurrent review requirements when contacting the member Home Plan for benefit and eligibility information.

Claim Submission

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How should providers bill claims for out-of-area members?

Providers should bill claims for out-of-area members the same way they bill claims for their local Blue Cross and Blue Shield Plan members. When submitting the claim:

- The member ID numbers should be reported exactly as shown on the ID card. Do not add, omit or alter any characters from the member ID number.
- Indicate on the claim any payment you collected from the patient.
- Only submit medical records if requested.

What should you do if you haven't received a response to your initial claim submission?

If you have a question regarding the status of an outstanding claim, you can submit an electronic Blue Exchange Claim Status Request (HIPAA transaction 276) or contact your local Plan.

Do not send in a duplicate claim. Sending another claim or having your billing agency resubmit claims automatically slows down the claims payment process and creates confusion for the member.

Coordination of Benefits

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How should Coordination of Benefits (COB) be handled when a member has Blue on Blue coverage or another carrier?

In cases where Blue on Blue coverage has been identified, and the member has dual coverage with the same and/or differing Blue Plans, you should consider the following:

- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification or ask them to complete the COB questionnaire available on your local Plan's website.
- On the electronic HIPAA transaction 837 or paper claim, it is important in box 11D to check "YES" or "NO" for professional claims or form fields 50 and 58-62 be completed for facility claims to ensure the claim will be reviewed properly by the local Blue Plan. For professional claims, it is imperative that you indicate if the member does not have other insurance. Leaving the box unmarked can cause the member's Home Plan to stop the claim to investigate for COB. By completing the information, you are helping to ensure your claim will be processed more timely.

- Review the Explanation of Payment/Explanation of Benefits (EOP/EOB) from the primary Blue Plan prior to submitting a claim to the secondary Blue Plan to avoid duplicate claims submission. The primary Blue Plan may have forwarded the claim to the secondary Blue Plan through BlueCard. If the secondary claim was not handled by the local Blue Plan then forward a copy of the claim to your local Blue Plan with any Other Party Liability (OPL) information included.
- Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability.

In cases where there is more than one payer and another Blue Plan or commercial insurance carrier is the primary payer, submit the other carrier's name and address or EOB with the claim to your local Plan. You may also go to your local Plan's website and download a copy of the COB questionnaire that the member can complete and sign at the time of service and send it to your local Plan with the claim. Please ensure that the form is completely filled out and at a minimum, include your name and tax identification or NPI number, the policy holder's name, group number and identification number including the three character alpha-prefix and the member's signature. Not including the COB information with the claim may delay payment if the members Home Plan investigates the claim needlessly.

If another non-Blue health plan is primary and any other Blue Plan is secondary, submit the claim to the local Plan only after receiving payment from the primary payer. Include the EOP/EOB from the primary carrier with your claim submittal.

Prior Authorization/Pre-Certification

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Are providers required to cooperate with the member's Blue Plan prior authorization/pre-certification programs?

While out-of-area BlueCard members are currently responsible for obtaining prior authorization or pre-certification from their BCBS Plans, most providers choose to handle this obligation on the member's behalf. Members may be held financially responsible if necessary approvals are not obtained and the claim is denied. The provider may have to manage debt collection in this situation.

When verifying member eligibility and benefits, providers should request information on prior authorization and pre-certification, care management/utilization management and concurrent review, as required for inpatient or outpatient services. Also refer to the Blue Cross and Blue Shield of New Mexico (BCBSNM) [preauthorization requirements](#).

How can providers obtain prior authorization/pre-certification information for out-of-area members?

Member prior authorization or pre-certification information can be obtained both electronically and telephonically.

- General information on prior authorization and pre-certification information can be found on the local Blue Plan web page under **Medical Policy and Preauthorization Information for Out-of-Area Members** utilizing the three letter prefix found on the member ID card.
- Providers can also contact 1-800-676-BLUE(2583) to obtain prior authorization or pre-certification information. When prior authorization or pre-certification for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles prior authorization or pre-certification. 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 prior authorization or pre-certification, through 1-800-676-BLUE(2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the prior authorization or pre-certification area.

Please note that if a prior authorization and pre-certification determination is not provided at the time of the call, the determination may be communicated to a different area (i.e. facility's Utilization Management area) than the area that initiated the pre-certification request. Providers are encouraged to ask the member's Blue Plan about this situation when they call in order to prevent duplicate requests.

- With the submission of an Eligibility HIPAA transaction 270 request through your local Blue Plan, the Eligibility HIPAA transaction 271 response may indicate that a prior authorization or pre-certification is required for an eligible service.

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Are facilities that are paid primarily on a DRG/case basis required to obtain approvals for length-of-stay beyond the original approval?

Whenever possible, member Home Plans will consider the local Plan's payment arrangement with the facility, and if appropriate, adjust UM protocols accordingly. Many DRG contracts have stop loss provisions and revert to an alternative payment method (i.e., percent of charges) at a particular point during the course of stay. These cases need to be managed appropriately. Member Home Plans may work closely with the facility and/or local Plan to manage these potentially high-cost cases.

- Claims could be subjected to length-of-stay review and potential sanctions. Providers cannot assume that if they are contracted as a DRG facility, no concurrent review will occur.
- The member Home Plan cannot "split" payment for claims with the local Plan DRG pricing. The member's Home Plan must either approve or deny the entire claim. They may not pay only for specific days and deny others.
- If the treatment plan changes during the inpatient stay, the original approval would not be applicable and new certification would need to be obtained. The provider can call 1-800-626-BLUE(2583) and request to speak with the Utilization Review area or submit a Blue Exchange Referral/Authorization Inquiry (HIPAA transaction 278) to the local Plan.
- Providers are encouraged to inquire about concurrent review process when verifying member eligibility and benefits or when obtaining pre-certification so they are aware of what steps are needed to satisfy the member's Home Plan concurrent review requirements. Provider benefits of the concurrent review process are:
 - Assist with coordinated discharge planning
 - Identify care management opportunities for the member
 - Help to reduce patient readmission

Why do member's Blue Plans sometimes initially indicate that a service/procedure is authorized or certified under an authorization or certification process, but when the service is adjudicated, determine the service to be non-covered/denied?

These discrepancies tend to occur when there is benefit limitations that restrict who may render the service, where they are rendered, how they are billed, or the presence of a benefit maximum. Additional factors that may affect adjudication of a claim are pre-existing conditions, additional services not included in the initial plan of treatment and/or a revised length of stay that does not match the prior authorization or pre-certification.

When obtaining prior authorization or pre-certification, please provide as much information as possible to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member's Blue 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 make the necessary notification or obtain prior authorization/pre-certification may cause a delay or denial in claims payment. Please note that prior authorization or pre-certification does not guarantee payment.

Are providers required to hold the patient harmless for penalties assessed for not following the member's Blue Plan authorization protocols?

The out-of-area BlueCard member is responsible for obtaining pre-certification or prior authorization from his/her Blue Cross and Blue Shield Plan. As a result, the member is responsible for any penalty assessed for non-compliance.

Medical Records

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Should a provider include medical records with the original claim?

Providers are not encouraged to submit medical records or other clinical information unless requested. If medical records or other relevant information is needed to finalize the claim payment, the local Blue Cross and Blue Shield Plan will notify you.

- If you receive requests for medical records from other Blue Plans *prior to rendering services*, as part of the prior authorization process, please submit them directly to the member's Plan that requested them.
- 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.
- There is a difference between reviewing a claim for medical necessity after the service has already been rendered and reviewing a prior authorization for medical appropriateness; these reviews are not the same:
 - Medical Necessity – validates the service is medically necessary according to their members Blue Plan medical policy.
 - Medically Appropriate – validates the service rendered matches the prior authorization and the dollar amounts are in-line.
- When a claim has been denied for medical records and the records have been submitted to your local Plan, it is recommended that providers wait at a minimum 20 business days before submitting a follow up request for status of claim adjudication.
- If you are the rendering or performing provider for a service, include the name and address of the referring or ordering provider on your original claim submission. Including this information will help ensure that if medical records are needed that they will be requested from the correct provider.

Which Plan's Medical Policy applies for out-of-area members?

Only a member's Blue Plan Medical Policy applies to BlueCard claims. The member's Blue Plan Medical Policy applies to the interpretation and determination of medical necessity, medical appropriateness, investigational/experimental care, and clinical reviews as related to administration of the member's benefits and coverage.

Should a member's Blue Plan ever directly contact an out-of-area provider?

The member's Blue Plan should only contact an out-of-area provider to solicit, clarify, or confirm clinical information for the purpose of performing case management or disease management activities.

How should providers bill mother/newborn claims for out-of-area members?

Providers should bill mother/newborn services for out-of-area members the same way they bill claims for local Blue Cross and Blue Shield members.

Who determines the use of revenue/procedure codes?

It is the local Plans responsibility for claims coding based on the contractual agreement with the provider. When a claim contains non-standard codes, it may be rejected back to the provider, and the provider may be asked to resubmit with the standard code.

Who determines the appropriate use of modifiers?

The local Blue Cross and Blue Shield Plan is responsible for determining the appropriate use of modifiers.

How much can a contracted provider bill an out-of-area Blue member?

Providers should only bill for applicable deductibles, copays, coinsurance, non-covered services and/or medical management penalties specifically indicated as "Patient Responsibility" on the remittance advice for such out-of-area Blue Plan members. The provider cannot, in any event, bill the out-of-area member for the difference between billed charges and the locally negotiated allowance.

What criteria are used to determine whether the charge associated with a rendered service is a member or a contracting provider's liability?

The criteria used to determine the provider's liability is specific to the provider's contract. If the provider's contract explicitly states the provider will not be reimbursed for a specific service or based on a specific timeframe, and cannot bill the member, the provider is liable for the charge.

The criteria used to determine the member's liability is specific to the member's benefit contract. If the member's benefit explicitly states the service is not covered, the member is liable for the charge.

Under what circumstances is there no payment due to the provider?

Your local Blue Plan prices claims according to the terms of its provider contracts. If a provider's contract has a clause stating providers are liable for any costs associated with services rendered outside the provider's scope of practice, your local Plan will indicate no payment is due to the provider. If the member's benefit allows the service, but the provider's contract does not, benefits will be approved, but no payment is due the provider according to his/her contract and the provider should write it off.

Claims Payment

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How is a provider payment determined?

- The local Plan applies pricing and reimbursement rules consistent with provider contractual agreements.
- The member's Home Plan adjudicates the claim based on eligibility and contractual benefits.

Who pays the provider?

Provider payable claims are paid by the local Plan based on the provider's contract and subject to the member's benefit plan.

Medicare Crossover

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All Blue Plans crossover Medicare claims for services covered under Medigap and Medicare Supplemental products. This results in automatic claims submission of Medicare claims to the Blue secondary payer, and reduce or eliminate the need for the provider's office or billing service to submit an additional claim to the secondary carrier.

How do I submit Medicare primary / Blue Plan secondary claims?

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

When should I expect to receive payment for Medicare Crossover claims?

The claims you submit to the Medicare intermediary will be crossed over to the Blue Plan after they have been processed by the Medicare intermediary. This process may take up to 14 business days. This means that the Medicare intermediary will be releasing the claim to the Blue Plan for processing about the same time you receive the Medicare remittance advice. As a result, it may take an additional 14-30 business days for you to receive payment from the Blue Plan.

To determine if your claim has crossed over, review the Remittance Advice (RA) you receive from Medicare. The RA will show a crossover indicator that Medicare has submitted the claim to the appropriate Blue Plan and the claim is in progress. If there is no crossover indicator on the RA, providers should submit the claim along with the Medicare RA to the local Plan.

How do I handle Medicare Advantage (MA) claims?

For Medicare Advantage, submit claims to the local Blue Plan. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

- Ask for the member ID card. Members will not have a standard Medicare card; instead, Medicare Advantage members have distinctive product logos on their medical ID card to help you recognize them. All logos have the term “Medicare Advantage” in the design.
- Verify eligibility by contacting 1-800-676-BLUE(2583) and providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply.

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

What does Medicare Advantage PPO Network Sharing mean?

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

Note: If you are not a contracted MA PPO provider with your local Plan and you provide services for any Blue 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.

Ancillary Claims Filing

Where should I file 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) – The Plan in whose state* the specimen was drawn.
- Durable/Home Medical Equipment and Supplies (D/HME) – The Plan in whose state* the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy – The Plan in whose state* 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.

Contiguous Counties/Overlapping Service Areas

What are the rules for filing claims for contiguous counties?

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contract, 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 Home Plan and where the member works and resides (i.e. is the member's Home Plan with one of the contiguous counties plans).
- The location of where the services were received (i.e. does the member work and reside in one contiguous county and see a provider in another contiguous county).

Note: Contiguous Counties guidelines do not apply to ancillary claims filing. Ancillary claims must be filed to the local Plan based on the type of ancillary service provided.

What are the rules for filing claims in overlapping service areas?

Submission of claims in overlapping service areas is dependent on what Plan(s) the provider contracts with in that state, the type of contract the provider has (e.g., PPO, Traditional) and the type of contract the member has with their Home Plan.

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

Additional Information

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What is an Administrative Services Only (ASO) account?

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 local plan 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. As with any member benefit contract be sure to verify member eligibility and benefits when rendering service.

How should clearinghouses be notified of changes in claims processing guidelines or policy?

It is the providers responsibility to ensure any changes to claims processing guidelines or policy is communicated to any billing service, clearinghouse or payer the provider has a vendor arrangement with to process your claims. Failure to do so in a timely manner may result in delays or denials of payment due to incorrect claims submission.