Blue Cross and Blue Shield of New Mexico

The BlueCard® Program Provider Manual

January 2013

The following information is provided to assist with provider education about BlueCard and inter-Plan business.

This information does not constitute, and is not intended as, legal or financial advice.

Note: Sections marked with an asterisk in the Table of Contents indicates a new or revised section since the last version of this manual was published.

Table of Contents

Note: * = New or revised section since the last version of this manual was published.

1. Introduction: BlueCard Program Makes Filing Claims Easy

As a participating provider of Blue Cross and Blue Shield of New Mexico (BCBSNM) you may render services to patients who are National Account members of other Blue Plans, and who travel or live in New Mexico.

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 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 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 submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue 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 Blue Plans, including international Blue Plans, directly to BCBSNM. BCBSNM will be your one point of contact for all of your claims-related questions.

More than 79,000 other Blue Plans' members are currently residing in New Mexico.

BCBSNM continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations.
In doing so, your patients will have a positive experience with each visit.

2.3 Products included in BlueCard

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue Plans offer all of these products to their members. Currently BCBSNM offers products indicated by the asterisk below, however you may see members from other Blue Plans who are enrolled in the other products:

- 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 will 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 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 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

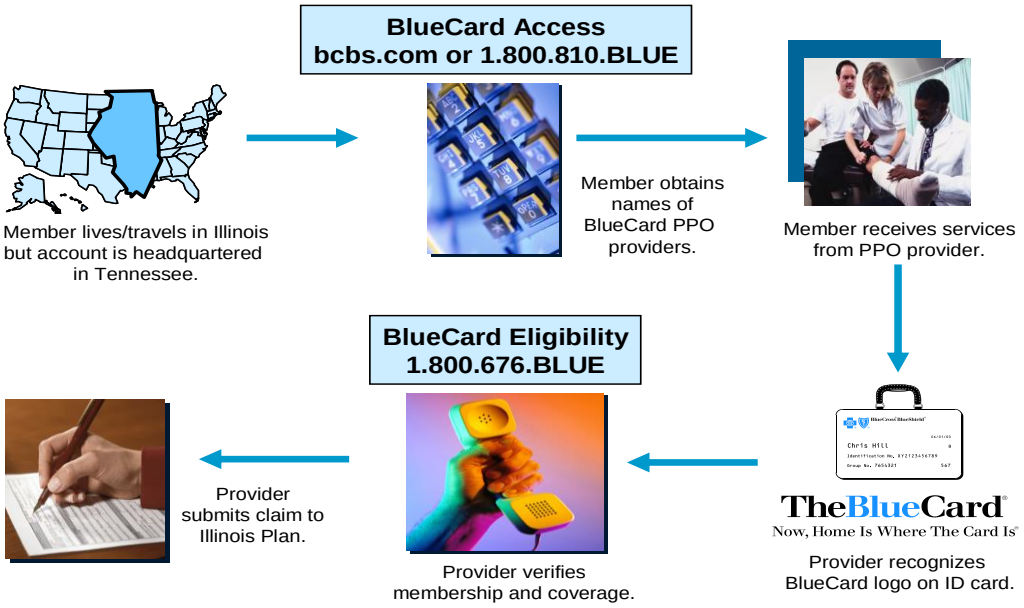
The following claims are excluded from the BlueCard Program:

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

Please follow BCBSNM billing guidelines.

*Medicare Advantage is a separate program from BlueCard, however since you might be seeing members of other Blue Plans who have Medicare Advantage coverage, we have included 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 BlueCard 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 internally 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 or 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 Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

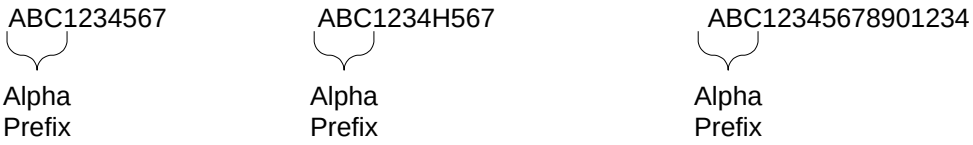
The main identifier for out-of-area members is the alpha prefix. The ID cards also may have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

Important facts concerning member IDs:

- A correct member ID number includes the alpha 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 alpha prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

Examples of ID numbers:



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 that you have the most up-to-date information in your patient'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: 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.

Alpha Prefix

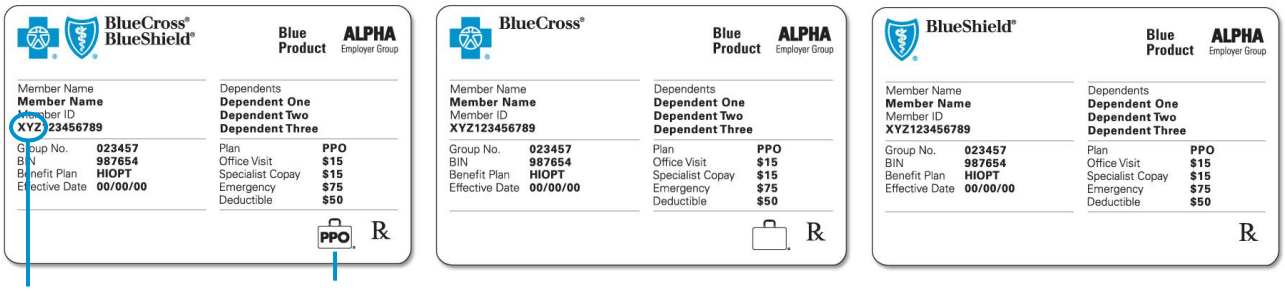
The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

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 the claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff.

Do not make up alpha prefixes.

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

Sample ID Cards



The three-character alpha prefix.

The "PPO in a suitcase" logo may appear in the lower right corner of the I.D. card.

BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO 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 BCBSNM's PPO provider contract. Please note, however, 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.

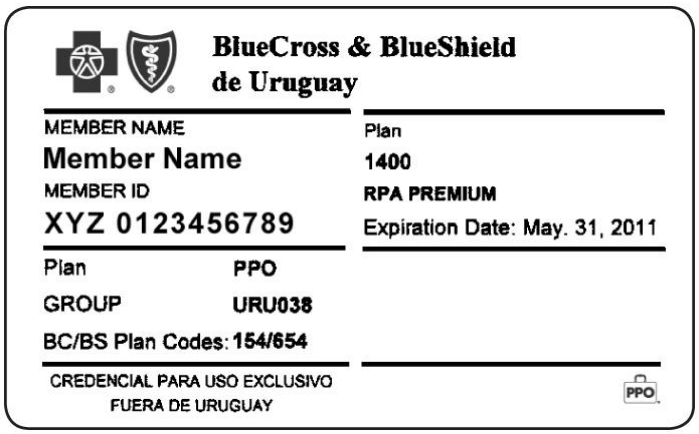
The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional or HMO coverage, you will be reimbursed according to BCBSNM's traditional provider contract.

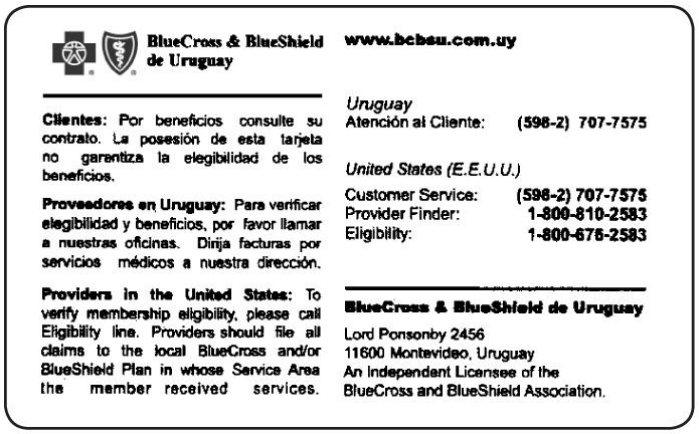
Some Blue ID cards don't have any suitcase logo on them. Those are the ID cards for Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement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

3.2 How to Identify International Members

Occasionally, you may see identification cards from Blue members of international Blue Plans, which include: BCBS of U.S. Virgin Islands, BCBS of Uruguay and BCBS of Panama. These ID cards will also contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members (e.g., do not collect any payment from the member beyond their cost-sharing amounts such as deductible, coinsurance, and copayment).

Sample image of an international ID card:





Note: The Canadian Association of Blue Cross Plans and its members are separate and distinct from the Blue Cross and Blue Shield Association and its members in the United States.

Claims for members of the Canadian Blue Cross Plans are not processed through the BlueCard Program. Please follow the instructions of these Plans and those, if any, on their ID cards for servicing their members. The Blue Cross Plans in Canada are:

Alberta Blue Cross	Atlantic Blue Cross Care	Saskatchewan Blue Cross
Manitoba Blue Cross	Quebec Blue Cross	Pacific Blue Cross

3.3 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.

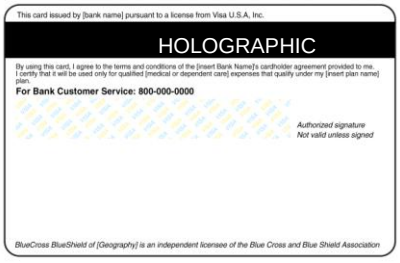
Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member's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

Some cards are "stand-alone" 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:

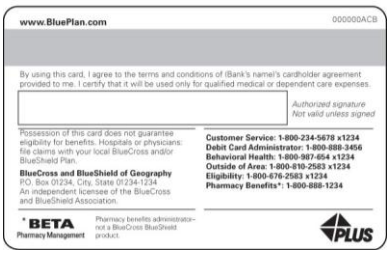
- Reduce bad debt.
- Reduce paperwork for billing statements.
- Minimize bookkeeping and patient-account functions for handling cash and checks.
- Avoid unnecessary claim payment delays.

The card will have the nationally recognized Blue logos, along with the logo from a major debit card such as MasterCard® or Visa®.

Sample stand-alone Health Care Debit Card



Sample combined Health Care Debit Card and Member ID Card



The cards include a magnetic strip allowing providers to swipe the card at the point of service and collect the member cost-sharing amount (i.e. copayment).

With health 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 appropriate member's HRA, HSA or FSA account.

Combining a health insurance ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone in order to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities.

If your office currently accepts credit card payments, there is no additional cost or equipment necessary. The cost to you is the same as what you pay to swipe any other signature debit card.

Helpful tips:

- Carefully determine the member's financial responsibility before processing payment. You can access the member's accumulated deductible by contacting the BlueCard Eligibility line at 1.800.676.BLUE (2583) or by using the local Plan's online services.
- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- If the member presents a debit card (stand-alone or combined), be sure to verify the out of pocket amounts before processing payment:
    - Many Plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member's benefits or to request accumulated deductible information, please contact 1.800.676.BLUE (2583).
    - You may use the debit card for member responsibility for medical services provided in your office.
    - You may choose to forego using the debit card and submit the claims to BCBSNM for processing. The Remittance Advice will inform you of the member's responsibility.
    - All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to the local Plan for proper benefit determination, and to update the member's claim history.
- Check eligibility and benefits electronically by accessing availity.com or by calling 1.800.676.BLUE (2583) and providing the member ID number including the alpha prefix.
- 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.

3.4 Limited Benefits Products

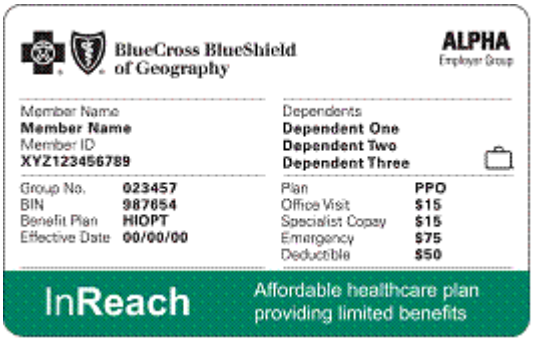
Verifying Blue patients' benefits and eligibility is now more important than ever, since new products and benefit types entered the market. In addition to patients who have traditional Blue PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e., $1million or more) you may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

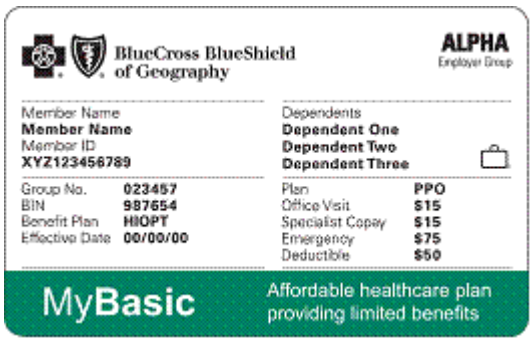
Currently BCBSNM doesn't offer such limited benefit plans to our members, however you may see patients with limited benefits who are covered by another Blue Plan.

How to recognize members with limited benefits products?
Patients who have Blue limited benefits coverage carry ID cards that have:

- Either of two product names — **InReach** or **MyBasic**
- A tagline in a **green stripe** at the bottom of the card and
- 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 and collect any patient liability or copayment.

You may call 1.800.676.BLUE (2583) eligibility line for out-of-area members. You will receive the patient's accumulated benefits to help you understand the remaining benefits left for the member.

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 might be member's liability.

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

3.5 Coverage and Eligibility Verification

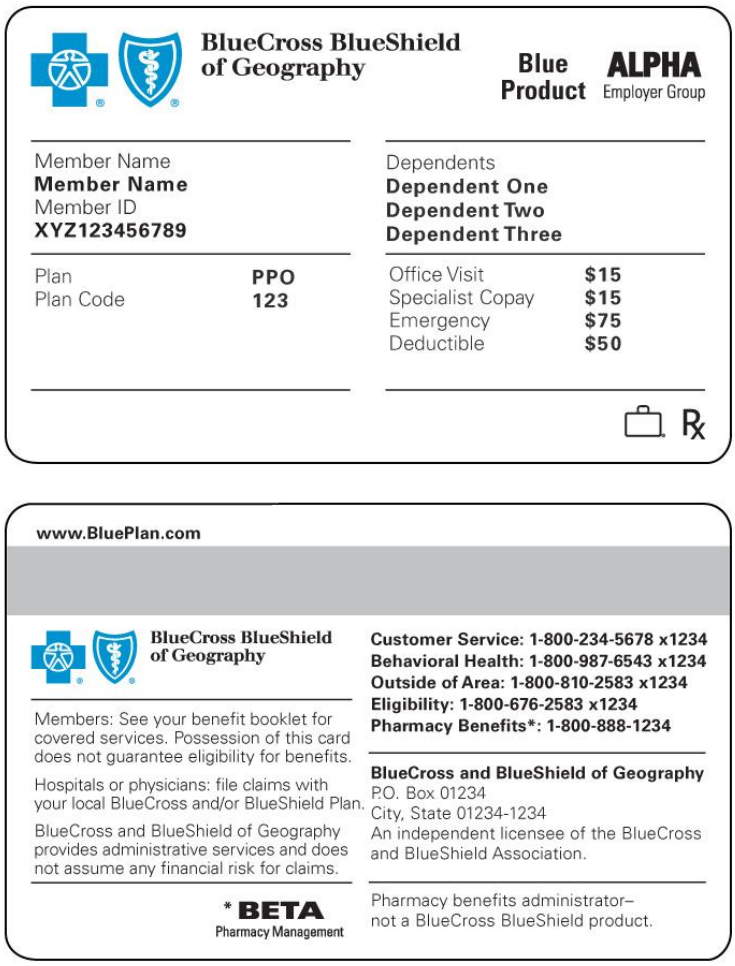
For BCBSNM members, contact the BCBSNM Provider Service Unit at 1-888-349-3706.

For other Blue Plans' members, submit an electronic inquiry to BCBSNM or call BlueCard Eligibility 1.800.676.BLUE (2583) to verify the patient's eligibility and coverage:

- Electronic—Submit a HIPAA 270 transaction (eligibility) to BCBSNM.

  You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and Midnight, Central Time, Monday through Saturday.
- Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583)
  - English and Spanish speaking phone operators are available to assist you.
  - Keep in mind that Blue Plans are located throughout the country and may operate on a different time schedule than BCBSNM. You may be transferred to a voice response system linked to customer enrollment and benefits.
  - 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.
- 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.
  - A Blue 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 Plan ID.
  - The PlanID data element identifies the health plan that issued the ID card. Plan ID will help providers facilitate health transactions among various payers in the marketplace.

- 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:



3.6 Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/ preauthorization for their services from their Blue Plan.

General information on pre-certification/preauthorization information can be found on the Out-of-Area Member Medical Policy and Pre-Authorization/Pre-Certification Router at bcbsnm.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 BCBSNM members, call 1-800-325-8334.
- For other Blue 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 Blue 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)

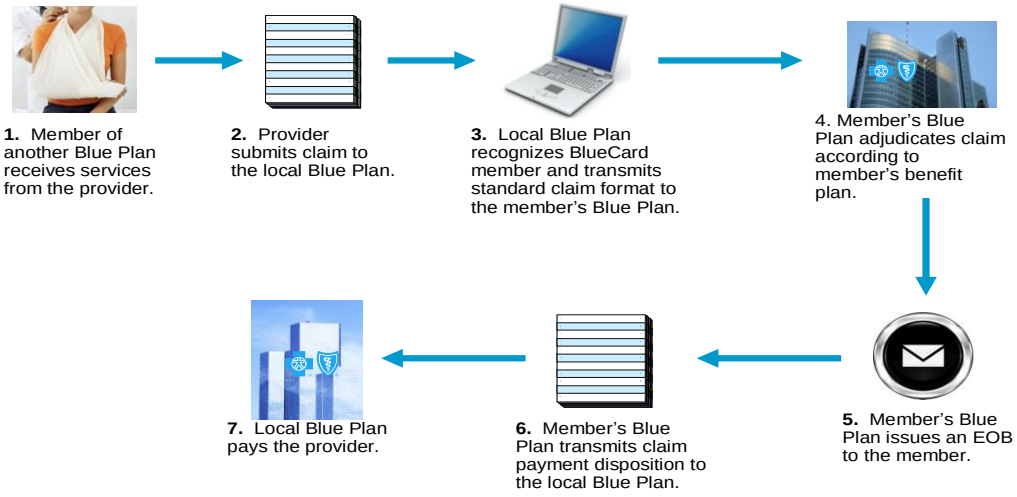
          If you are inquiring about both, eligibility and pre-certification/pre-authorization, through 1-800-676-BLUE(2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.
    - Submit an electronic HIPAA 278 transaction (referral/authorization) to BCBSNM.
    - The member's Blue 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 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 obtain approval for the additional days may result in claims processing delays and potential payment denials.

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 Blue Plan receives services from you, you should file the claim with BCBSNM. 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, and 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.

You should always submit claims to BCBSNM.

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 alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at www.availity.com or by calling 1.800.676.BLUE (2583). Be sure to provide the member's alpha prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment up front.
- Indicate on the claim any payment you collected from the patient. (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 Blue claims to BCBSNM, P.O. Box 27630, Albuquerque, NM 87125-7630. Be sure to include the member's complete identification number when you submit the claim, including the three-character alpha prefix. Submit claims with only valid alpha-prefixes; claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.
- In cases where there is more than one payer and a Blue Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue claim. Upon receipt, BCBSNM will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment; BCBSNM 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 contacting BCBSNM at 1-800-222-7992 or submitting an electronic HIPAA 276 transaction (claim status request) to BCBSNM.

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.

Effective January 1, 2010, 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 physicians and providers on a fee-for-services basis 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 BCBSNM.
- 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.
- For your convenience, you will find MA PFFS Terms and Conditions for all Blue Plans at: bcbsnm.com/provider by providing the member's three-letter alpha prefix
- Submit your MA PFFS claims to BCBSNM.

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?

Beginning January 1, 2010, Network sharing allows MA PPO members from MA PPO Blue 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 Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 18 states and one territory:

Alabama	California	Florida	Idaho
Indiana	Kentucky	Massachusetts	Michigan
Missouri	New York	Nevada	North Carolina
Ohio	Pennsylvania	South Carolina	Tennessee
West Virginia	Wisconsin		Puerto Rico

What does the BCBS Medicare Advantage PPO Network Sharing mean to me?

There is no change from your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat. Benefits will be based on the Medicare allowed amount for covered services and be paid under the member's out-of-network benefits unless for urgent or emergency care. Once you submit the MA claim, BCBSNM will send you the payment.

How do I recognize an out-of-area member from one of these Plans?

The *"MA"* in the suitcase on the member's ID card indicates a member who is covered under the 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 these Medicare Advantage PPO network sharing members or other Blue MA members from out-of-area?

You may see any out-of-area Blue Medicare Advantage members but you are not required to provide services. Should you decide to provide services to any Blue Medicare Advantage out-of-area 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.

If I chose to provide services, how do I verify benefits and eligibility?

Call BlueCard *Eligibility* at 1.800.676.BLUE (2583) and provide the member's alpha prefix located on the ID card.

Where do I submit the claim?

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

What can I expect for reimbursement?

Benefits will be based on the Medicare allowed amount for providing covered services to any Blue Medicare Advantage out-of-area members. Once you submit the MA claim, BCBSNM will send you the payment. These services will be paid under the members out-of-network benefits unless services were for urgent or emergency care.

What is the member cost sharing level and copayments?

Any Blue MA members from out-of-area will pay their out-of-network cost sharing amount based on their health plan. You may collect the copayment amounts from the member at the time of service.

May I request payment up front?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, 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.

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 balanced billed for any deductibles, coinsurance, and/or copayments.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact your local Plan at 1-888-349-3706.

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 BCBSNM at 1-888-349-3706.

4.2.3 Eligibility Verification

- Verify eligibility by contacting 1.800.676.BLUE (2583) and providing an alpha prefix or by submitting an electronic inquiry to your local Plan and providing the alpha prefix.
- Be sure to ask if Medicare Advantage benefits apply.
- If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSNM.

4.2.4 Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to BCBSNM.
- 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 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 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 Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., copayment) 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 copayment (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 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. You can find the MA PFFS Terms & Conditions using the web locator at bcbsnm.com/provider. Simply enter the member's three-letter alpha prefix.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) 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 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 a MA HMO member from the local Plan.

If you are a provider who accepts Medicare assignment and you render services to any Blue Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue 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 Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) 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.

4.3 Claim status inquiries

You can make claim status inquiries through BCBSNM by:

- Phone – call 1-800-222-7922 Monday through Friday, 5:00 a.m. to 10:30 p.m., and Saturday from 5:00 a.m. to 2:00 p.m. (Mountain time)
- Electronically – send a HIPAA transaction 276 (claim status inquiry) to BCBSNM.

4.4 Utilization review

Follow the same protocol as you do for any other Blue members, if authorization/pre-certification is needed. (See Section 3.6 above)

4.5 Traditional Medicare-Related Claims

The following guidelines are for processing of traditional Medicare-related claims:

- When Medicare is primary payer, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross-over to the member's Blue Plan after being adjudicated by the Medicare intermediary.

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.
- Include the alpha prefix as part of the member identification number. The member's ID 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 you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. ***DO NOT*** resubmit that claim to BCBSNM.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BCBSNM 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 the BlueCard Provider Service Unit at 1-800-222-7992.

When should I expect to receive payment?

Claims submitted to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed. 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.

What should I do in the meantime?

If you submitted the claim to the Medicare intermediary/carrier, and haven't received a response to your initial claim submission, don't automatically submit another claim. Rather, you should:

- Review the automated resubmission cycle on your claim system.
- Wait 30 days.
- Check claims status before resubmitting.

Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claim payment process and creates confusion for the member.

Who do I contact if I have questions or to check claim status?

If you have questions, please call the BlueCard Provider Service Unit at 1-800-222-7992.

4.6 International Claims

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to BCBSNM. See Section 3.2 for servicing foreign members and the note regarding members of the Canadian Blue Cross Plans.

4.7 Coding

Code claims as you would for BCBSNM claims.

4.8 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 county claims filing rules do not apply to ancillary claims.

Provider Type	How to file (required fields)	Where to file	Example
Independent Clinical Laboratory (any type of non hospital based laboratory) Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.	**Referring Provider**: – Field 17B on CMS 1500 Health Insurance Claim Form or – Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose state the ***specimen was drawn**** * Where the ***specimen was drawn*** will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in **New Mexico.** Blood analysis is done in **California.**. *File to:* **New Mexico.** *Claims for the analysis of a lab must be filed to the Plan in whose state the ***specimen was drawn***.
Durable/Home Medical Equipment and Supplies (D/HME) Types of Service include, but are not limited to: hospital beds, oxygen tanks, crutches, etc.	**Patient's Address**: – Field 5 on CMS 1500 Health Insurance Claim Form or – Loop 2010CA on the 837 Professional Electronic Submission. **Ordering Provider**: – Field 17B on CMS 1500 Health Insurance Claim Form or – Loop 2420E (line level) on the 837 Professional Electronic Submission. **Place of Service**: – Field 24B on the CMS 1500 Health Insurance Claim Form or – Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. **Service Facility Location Information**: – Field 32 on CMS 1500 Health Insurance Form or – Loop 2310C (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan in whose state the equipment was ***shipped to or purchased in a retail store.***	A. Wheelchair is purchased at a retail store in **New Mexico**. *File to:* **New Mexico** B. Wheelchair is purchased on the internet from an online retail supplier in **Ohio** and shipped to **New Mexico.** *File to:* **New Mexico** C. Wheelchair is purchased at a retail store in **New Mexico** and shipped to **Arizona.** *File to:* **Arizona**

Provider Type	How to file (required fields)	Where to file	Example
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.	**Referring Provider**: – Field 17B on CMS 1500 Health Insurance Claim Form or – Loop 2310A (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan whose state the ***Ordering Physician is located***.	Patient is seen by a physician in **New Mexico** who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in **Colorado** where the member lives for 6 months of the year. *File to:* **New Mexico**

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue 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, 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 possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by using the Provider Finder® at bcbsnm.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 BCBSNM to obtain additional contact information.
- If you have any questions about where to file your claim, please contact the BCBSNM Provider Service Unit at 888-349-3706.

4.9 Contiguous Counties

4.9.1 Contiguous Counties

Claims filing rules for contiguous area providers are 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 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.

4.10 Medical Records

Medical Records

Blue Plans around the country have made improvements to the medical records process to make it more efficient. We now are able to send and receive medical records electronically among each other. This new 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 preauthorization process* — If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the preauthorization 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 BCBSNM.
2. *As part of claim review and adjudication* — These requests will come from BCBSNM in the form of a letter 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 call the BlueCard Provider Service Unit at 1-800-222-7992 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 BCBSNM 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 BCBSNM.
2. Follow the submission instructions given on the request, using the specified 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 BCBSNM.
4. Please submit the information to BCBSNM 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.

4.11 Adjustments

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

4.12 Appeals

Appeals for all claims are handled through BCBSNM. We will coordinate the appeal process with the member's Blue Plan, if needed.

4.13 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 that one health plan, and:

- BCBSNM or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to BCBSNM. If you do not include the COB information with the claim, the member's Blue Plan 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.
- Other non-Blue health plan is primary and BCBSNM or any other Blue Plan is secondary, submit the claim to BCBSNM only after receiving payment from the primary payer, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan 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.

- Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the BCBSNM 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 BCBSNM.

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, Coordination of Benefits (COB) questionnaire is available to you at bcbsnm.com/provider/forms that will help you and your patients avoid potential claim issues.

When you see any Blue members and you are aware that they might have other health insurance coverage (e.g., Medicare, Aetna, United Healthcare, etc.), 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 alpha-prefix and the member's signature. Once the form is complete, send it to your local Blue Plan as soon as possible. Your local Blue 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.

4.14 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 also causes member confusion because of multiple Explanations of Benefits (EOBs). BCBSNM's standard time for claims processing is 10 to 14 days. However, claim processing times at various Blue Plans vary.
- If you do not receive your payment or a response regarding your payment, please call BCBSNM at 1-800-222-7992 or visit www.availity.com to check the status of your claim.
- 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, BCBSNM may either ask you for the information or give the member's Plan permission to contact you directly.

4.15 Claim Status Inquiry

BCBSNM is your single point of contact for all claim inquiries.

Claim status inquires can be done by:

- Phone – call 1-800-222-7922 Monday through Friday, 5:00 a.m. to 10:30 p.m., and Saturday from 5:00 a.m. to 2:00 p.m. (Mountain time)
- Electronically – send a HIPAA transaction 276 (claim status inquiry) to BCBSNM.

4.16 Calls from Members and Others with Claim Questions

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

The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to BCBSNM.

4.17 Key Contacts

For more information:

- Visit the BCBSNM Website at www.bcbsnm.com/provider
- Call BCBSNM at 1-800-222-7992
- Contact your BCBSNM provider service representative at 1-800-567-8540

5. Frequently Asked Questions

5.1 BlueCard Basics

1. 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 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 Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue 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 BCBSNM billing guidelines.

** Medicare Advantage is a separate program from BlueCard, however since you might be seeing members of other Blue Plans who have Medicare Advantage coverage, we have included a section on Medicare Advantage claims processing in this manual.*

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. 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 the same way as you do for BCBSNM members and Blue traditional, PPO, and POS patients from other Blue Plans by submitting them to the BCBSNM Plan.

5.2 Identifying Members and ID Cards

7. How do I identify members?

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

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

8. What is an "alpha prefix?"

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

9. What do I do if a member has an identification card without an alpha prefix?

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

10. How do I identify Medicare Advantage members?

Members will not have a standard Medicare card; instead, a Blue 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:

11. How do I identify international members?

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

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

The member or patient should contact their Blue Plan for a replacement card and/or proof of insurance. If the member or patient is unable to verify proof of insurance, the provider may charge the patient for payment in full at the time of service.

5.3 Verifying Eligibility and Coverage

13. How do I verify membership and coverage?

For BCBSNM members, contact 1-800-222-7992 or access www.availity.com

For other Blue Plan members, contact www.availity.com electronically or BlueCard Eligibility by phone to verify the patient's eligibility and coverage:

Electronic—Submit a HIPAA 270 transaction (eligibility) to BCBSNM.

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

5.4 Utilization Review

14. How do I obtain utilization review?

You should remind patients that they are responsible for obtaining pre-certification/authorization for their services from their Blue Plan.

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

For BCBSNM members, contact BCBSNM Health Services Department at 1-800-325-8334.

For other Blue Plans 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 of 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) to BCBSNM.

5.5 Claims

15. Where and how do I submit claims?

You should always submit claims to BCBSNM, P.O. Box 27630, Albuquerque, NM 87125-7630. Be sure to include the member's complete identification number when you submit the claim, including the three-character alpha prefix. Do not make up alpha prefixes. Claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.

16. How do I submit international claims?

The claim submission process for international Blue Plan members is the same for domestic Blue Plan members. You should submit the claim directly to BCBSNM.

17. 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 BCBSNM is the primary payer, submit the claim with information regarding COB to BCBSNM.

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.

18. How do I handle Medicare Advantage claims?

Submit claims to BCBSNM. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan.

19. How do I handle traditional Medicare-related claims?

- When Medicare is primary payer, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross over to the member's Blue Plan after being adjudicated by the Medicare intermediary.

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

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. ***DO NOT*** resubmit that claim to BCBSNM; 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 BCBSNM 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 the BlueCard provider Service Unit at 1-800-222-7992.

20. When will I get paid for claims?

BCBSNM's standard time for claims processing is 10 to 14 days; however, claim processing times will vary between Blue Plans. For claim status, contact the BCBSNM Provider Service Unit at 1-888-349-3706.

5.6 Contacts

21. Who do I contact with claims questions?

All inquiries should be directed to the BCBSNM BlueCard Provider Service Unit at 1-800-222-7992.

22. 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 Plan should not contact you directly, unless you filed a paper claim directly with that Plan. If the member's Plan contacts you to send it another copy of the member's claim, refer the Plan to BCBSNM.

23. Where can I find more information?

For more information:

- Visit BCBSNM website at www.bcbsnm.com
- Call BCBSNM at 1-800-222-7992
- Contact your BCBSNM provider service representative at 1-800-567-8540.

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 BCBSNM 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.

Alpha Prefix

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The alpha prefix identifies the member's Blue Plan or National Account and is required for routing claims.

bcbs.com

Blue Cross and Blue Shield Association's Web site, which contains useful information for providers.

BlueCard Access® 1.800.810.BLUE (2583)

A toll-free 800 number for you and members to use to locate healthcare providers in another Blue 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 Blue Plans.

BlueCard PPO

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.

BlueCard PPO Member

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard Doctor & Hospital Finder Web Site

http://www.bcbs.com/healthtravel/finder.html

A Web site you can use to locate healthcare providers in another Blue 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 Web site, please contact BCBSNM.

BlueCard Worldwide®

A program that allows Blue members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of foreign Blue Cross and/or Blue Plans to access domestic (United States) Blue provider networks.

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.

EPO

An Exclusive Provider Organization or EPO is a health benefits program in which the member receives no benefits for care obtained outside the 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 Blue Plan as full payment for these services.

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 6 and low-income pregnant women, Medicaid is governed by overall 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

"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.

Medicare Crossover

The Crossover program was 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 Home Plan via 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 Blue Plan's Service Area.

Other Party Liability (OPL)

Cost containment programs that ensure that Blue 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 Blue Plan.

POS

Point of Service or POS is 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.

PPO

Preferred Provider Organization or PPO is 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.

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

Traditional coverage is a health benefit plan that 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 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 alpha 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) to the local Plan.
- Submit the claim to BCBSNM, P.O. Box 27630, Albuquerque, NM 87125-7630. Always include the patient's complete identification number, which includes the three-character alpha prefix.
- For claims inquiries, call the BCBSNM BlueCard Provider Service Unit at 1-800-222-7992.