Communications

TABLE OF CONTENTS

Go to Table of Contents

I. Web Site

The Blue Cross and Blue Shield of Kansas Web site www.bcbsks.com offers providers fast, easy access to a wide range of information including:

- ❖ Claim Status information*
- ❖ Eligibility Information*
- ❖ Remittance Advices
- ❖ Newsletters
- ❖ Manuals
- ❖ Workshop Information
- ❖ Education Material
- ❖ Medical Policies
- ❖ ASK/EDI
- ❖ And More

Much of the information on our Web site (i.e. policies and procedures, claim status, eligibility, remittance advice) is confidential and therefore, accessing it is a secure process. It requires the user to create a "profile" during their first visit. Then on subsequent visits, the information established during the first visit is used to validate that the person has legitimate authorization.

When you're visiting www.bcbsks.com for the first time, our user-friendly instructions will assist you in establishing a secure profile.

Non-confidential information such as provider publications can be accessed without establishing a provider profile.

*Claim status and eligibility information is also available for out-of-area members.

If the ID number you enter is for an out-of-area member (including FEP), the system will ask for additional information such as member name, date of birth, gender, relationship to insured, etc.

The "Patient Claim Status Response" screen for out-of-area members will differ from Kansas members in that the screen will not include a link for viewing the remittance advice or the patient claim details screen.

Because out-of-area inquiries are accessing information from other plans, response time may take up to 50 seconds.

Go to Table of Contents

II. Interactive Voice Response (IVR)

The IVR uses an exchange of spoken information between the person calling and the system to authenticate provider telephone calls and furnish information about claim status and eligibility.

All incoming provider telephone calls for our customer service center and pre-certification department will initially be handled by the IVR. The first step the IVR will take is to **AUTHENTICATE THE CALL**. The authentication process differs a little depending on which department you're calling, but you need to be prepared to furnish the following information:

- Who is calling? Member or provider?
- If provider, are you a doctor or a hospital? (This system only offers these two choices. All professional providers would say doctor and all facility/institutional providers would say hospital.)
- NPI
- Telephone number
- Patient's identification number
- Patient's name
- Patient's date of birth
- Pre-certification number (if applicable)

If later your call is transferred to a customer service center representative or pre-certification analyst, this authenticated information will transfer with the call. (If your call is directed to a department other than customer service or pre-certification, the authenticated information will not transfer.)

After the authentication process:

- If you called the pre-certification department, a pre-certification analyst will handle the remainder of your call.
- If you called the customer service center, the IVR will ask if this call is about claim status, eligibility or some other issue. Claim status and eligibility calls will continue to be handled by the IVR. Calls about other issues will be directed to a customer service representative.

THROUGH A SPOKEN EXCHANGE OF INFORMATION BETWEEN THE CALLER AND THE IVR THE FOLLOWING CLAIM STATUS AND ELIGIBILITY INFORMATION IS AVAILABLE:

CLAIM STATUS	ELIGIBILITY
• date processed	• level of benefit

Go to Table of Contents

- amount paid
- who was paid
- total patient responsibility
- provider's contractual obligation
- patient coinsurance
- patient deductible
- patient co-payment

- coverage level (single/family)
- effective and/or termination dates
- time period (calendar year, contract year)
- deductible amounts
- coinsurance percentages and maximums
- amounts already applied to deductible and/or coinsurance
- office visit copay
- emergency room copay
- inpatient copay

At the end of either a claim status or eligibility IVR exchange, the caller can furnish a fax number and a recap of the information will be faxed to them.

HELPFUL HINTS WHEN USING THE IVR:

- Speak in your normal tone of voice and at your regular pace.
- Always use the member's most current BCBSKS identification number.
- Hours of operation are:
    - Tuesday – Saturday: midnight to 2:00 a.m. CT
    - Sunday: 6:00 p.m. to midnight CT

- Anyone who uses this system regularly will quickly become familiar with the flow of information. If you know what your response will be to a certain prompt without listening to the entire question, you can interrupt the IVR by speaking the answer at any time during the question. Remember, the IVR must start the prompt/question before it will recognize your response.

III. Inquiries

Inquiries can be sent to BCBSKS by:

- Mail
- Email
- Telephone

Be sure to include:

- Patient Name
- Member Name
- Identification Number (including alpha prefix)
- Service Date
- Complete Statement of Question/Problem
- Provider Number, Name and Address
- Inquirer's Name
- Inquirer's Telephone Number

Go to Table of Contents

A. MAIL

Inquiries can be mailed to:

Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka KS 66629-0001

Providers can use the on-line CLAIMS/ENROLLMENT INQUIRY form or submit a paper inquiry using the Claim/Enrollment Inquiry form (34-58 12/03) located in this section.

B. Email

Inquiries can be sent to: csc@bcbsks.com

BCBSKS respects the privacy of our member's, healthcare providers and partners and therefore, uses secure email in many of our electronic communications.

If you need to include private information in your email, please use our secure email.

Go to Table of Contents

CLAIM / ENROLLMENT INQUIRY

BlueCross BlueShield of Kansas*

For status of claim information please check our Web site – www.bcbsks.com

PLEASE CONFINE QUESTIONS TO ONE PATIENT OR MEMBER PER FORM

☐ Retrospective Review ☐ First Level Appeal ☐ Second Level Appeal

Date inquiry mailed ________________

Group name ________________

Group number ________________

- ☐ State and State Medicare Exclusion- Send to State Customer Service
- ☐ Other Claims: Blue Cross, Blue Shield Major Medical, Medicare Exclusion Send to CSC
- ☐ Enrollment - Send to CSC ☐ New Address
- ☐ CSC/FEP Unit
- ☐ Plan 65 - Send to CSC
- ☐ Blue Select - CSC
- ☐ Premier Blue *
- ☐ Coordination of Benefits (DC, WC, NF, SB)
- ☐ Pre-existing

Patient's name ________________

Relationship to member ☐ Self ☐ Spouse ☐ Dependent

Member's name ________________

Member's address ________________
Street

City State ZIP code

ID number ________________

HI number ________________
(Include **both** numbers for Medicare Comp. Coverage)

Telephone of member/beneficiary

Home: ________________

Work: ________________ Ext: ________

Admission or Service Date	Type Service	Procedure Code	Charge	Paid Date	Patient Acct. #

Question: ________________

Name of Person Inquiring ________________

Provider Number ________________ Provider Name ________________

(Sender Retains White Copy, Responder Retains Yellow Copy)

Claim control # ________________

Answer: ________________

Respondent's name Date answered

CUSTOMER SERVICE CENTER

SEND REPLY TO:

Cost Center

Name

Street Address

CC:

City State ZIP Code

34-58 12/03

*Independent Licensees of the Blue Cross and Blue Shield Association.

Go to Table of Contents

C. Telephone

All telephone inquiries for claim status or eligibility information will be handled by the customer service center interactive voice response (IVR). Our customer service center representatives are available to handle other and more complex inquiries.

BLUE CROSS AND BLUE SHIELD CUSTOMER SERVICE – general inquiries including remittance advice questions, claim status and claim adjustment requests:

1-800-432-3990 Topeka
(785) 291-4180 Topeka

** VISIT OUR WEB SITE www.bcbsks.com FOR ONLINE CLAIM STATUS AND ELIGIBILITY INFORMATION **

- PROVIDER BENEFIT LINE: 1-800-432-0272 or (785) 291-4183
  Benefit information, coverage verification, eligibility waiting period clarification.

- STATE OF KANSAS EMPLOYEES:	1-800-332-0307 or (785) 291-4185
- FEDERAL EMPLOYEES:	1-800-432-0379 or (785) 291-4181
- For hearing impaired customers:	1-800-430-1270
- BlueCard Program for benefits and eligibility	1-800-676-BLUE (2583)
- BlueCard Program claim inquiries	1-800-432-3990 ext. 4058 (785) 291-4058
OTHER PARTY LIABILITY:	1-800-430-1274 or (785) 291-4013
PRE-EXISTING UNIT:	1-800-430-1274 or (785) 291-4013

BLUE CROSS AND BLUE SHIELD OF KANSAS PRECERTIFICATION/CONCURRENT REVIEW/ALTERNATIVE CARE/CASE MANAGEMENT
(use this number regardless of provider location or type of review being requested.) The IVR will authenticate and direct your call.

Toll Free 1-800-782-4437

Go to Table of Contents

NEW DIRECTIONS:

1-800-952-5906 or (785) 233-1165

NETWORK CONTROL: 1-800-432-0378 option 2
or (785) 291-4357 option 2

To release suspended sign-on passwords, research phone line problems or network problems.

ELECTRONIC MEDIA SERVICES: 1-800-472-6481 or (785) 291-4178

Software or equipment problems, installations for new providers, pricing and purchase information for equipment,

All UB-04/837I RJE (batch) transaction questions, batch specs, reports and testing.

KANSAS HEALTH DATA SYSTEM

(785) 291-8830
(785) 291-8702

Questions relating to the KHDS abstract process

BLUE SHIELD PROFESSIONAL RELATIONS HOTLINE

1-800-432-3587 or (785) 291-4135
E-mail: services.profrelations@bcbsks.com

CMS-1500 billing questions, reimbursement and Blue Shield contract information.

TRICARE
Provider Relations: (785) 291-7507
E-mail: TriWest@bcbsks.com

[Go to Table of Contents]

IV. Overpayments

A. Refund/Deduct Authorization Form (29-202 6/01)

When providers discover an overpayment they need to notify BCBSKS.

By using the Refund/Deduct Authorization, you can:

- Enclose a refund check
- Request that the money be deducted
- Request that a refund letter be sent

This form can be accessed, completed and emailed at our Web site (click here) or you can complete a paper version and mail it to us (click here).

B. Refund Request

BCBSKS uses an automated accounts receivable system for handling refunds. When we discover overpayments the provider will receive a listing of patients for which a refund is needed.

An example of a listing and the corresponding reason codes appear on the next pages.

Based on the contracting provider agreement, BCBSKS has the right to offset overpayments from future payments. Thirty days after issuing the refund notice, if BCBSKS has not received the refund nor has the provider contacted us in disagreement, the overpayment will be deducted.

The listing includes the following information.

REMIT CHECKS PAYABLE TO=	indicates who the provider should refund to.
SRVC DATE =	service date.
CONTROL NUMBER =	the Blue Cross claim control number.
PATIENT'S NAME =	(self-explanatory)
RS CD =	reason code indicating why the refund is being requested. A list of reason codes is included in this section.

Go to Table of Contents

TRANSACTION AMOUNT=	the amount of refund due.
PAID DATE=	the date the claim was processed.
REFERENCE NUMBER=	the Blue Cross identification number.

REMIT CHECKS PAYABLE TO:

PROVIDER NAME AND ADDRESS	BLUE CROSS AND BLUE SHIELD OF KS COST CENTER 830 1133 SW TOPEKA BLVD TOPEKA KS 66629-0001

CORPORATION: RFNDS CUSTOMER: DATE

THE FOLLOWING CLAIMS HAVE BEEN PAID TO YOU IN ERROR. REFER TO THE REASON CODE FOR AN ADDITIONAL EXPLANATION.

SRVC DATE	CONTROL NUMBER	PATIENT'S NAME	RS CD	TRANSACTION AMOUNT	PAID DATE	REFERENCE NUMBER
031902	150109909999	MARTIN ROGER	06	205.17	060492	123456789
061702	100201609999	JOHNSON SCOTT	04	1181.25	060492	234567890
		TOTAL DUE	$	1386.42		

Go to Table of Contents

REASON CODES FOR REFUND REQUEST

01	Maximum benefit has already been paid.
03	Payment was made to you in error. Services should be processed to another payee.
04	Paid under the incorrect identification number.
05	Services were billed in error.
06	Provider overcharged in error.
07	This claim overpaid on coinsurance, r deductible and/or copay.
08	Processed with incorrect total charges.
09	The patient is related to the provider.
10	Services should be billed by and paid to LabOne.
11	Claim paid with the incorrect performing provider number.
12	The waiting period for this service was not met.
13	This amount is a provider write-off.
14	services were not authorized as required.
16	No documentation to support these services.
17	Processed under the wrong patient.
18	We have paid over the maximum allowed.
19	Should have paid at 50%.
20	Service is considered content of another service which has been allowed.
21	Processed using the incorrect coding.
22	Processed with wrong service date. The correct service date has been paid.
23	Contract terminated before services were received.
24	Overpayment on this service was made.
25	Payment was made on a pre-determination claim.
26.	Corrected claim received.
35	This patient was not eligible at the time of service.
36	This patient elected not to enroll in Medicare Part B. We must pay as if Medicare was involved.
39	Medicare is primary and must process services first.
40	We overpaid as secondary to Medicare.
41.	Veterans Administration – overpaid as secondary (MRA).
47	Services were processed twice.
53	Services should be processed in another State or by another carrier.
64	This service is not covered.
71	The medical necessity for this service has not been verified.
78	This service should be submitted to the no-fault automobile insurance.
80	Provider is ineligible.
83	This service was related to an on-the-job injury or illness.
84.	We overpaid as secondary to another insurance carrier.
97	This service must be processed by the primary insurance carrier first.

Go to Table of Contents

C. Automatic Deduction

For hospitals who have agreed to automatic deduction, no refund request letter will be sent. The overpayment will be deducted and you will receive a "Notice of Blue Cross Deduction" letter.

Notice of Blue Cross Deduction

(date)

(hospital name)
and
(address)

IDENTIFICATION #:____
GROUP #:____
PATIENT ACCOUNT #:____
DATE OF SERVICES:____

A benefit payment error has been made for services provided to the above patient. Our records indicate that (reason for overpayment).

Benefits of ($ amount) were paid to you on (date). To correct the error, we will be withholding ($ amount) from your provider payment within the next few days.

If you have further questions or concerns, please contact our customer service center at (785) 291-4180 or toll free 1-800-432-3990.

Go to Table of Contents

V. Credit Balance Audits

Many circumstances can create an overpayment or a credit balance on a patient's account. When a credit balance occurs providers should follow the voluntary refund process to clear the account or if necessary, work with our customer service center to resolve outstanding issues leading up to clearing the account. If a credit balance is not resolved in a timely manner (within six months), you can submit a credit balance report to BCBSKS Institutional Provider Relations and we will assist in resolving outstanding accounts.

Goal of Credit Balance Audits

- Ensure member accounts are correct and resolved timely
- Certify that provider payments are correct
- Resolve outstanding claims issues timely to reduce administrative burdens for providers and BCBSKS

Tracking Credit Balances

Providers need to develop a system for reporting and handling credit balances. This could include:

- Excel spreadsheet
- Communications log used to show follow-up activity
- Timely follow up

Credit Balance Audit Documentation

Credit balances that have not been resolved through normal channels within six months can be submitted to Institutional Provider Relations for resolution assistance. You can either give them to your Institutional Provider Relations Consultant when they're visiting your facility or mail them to:

Institutional Relations cc442E2
Blue Cross and Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629

Go to Table of Contents

Providers need to include:

- Claim specific detail
  - ✓ Patient name
  - ✓ Date of service
  - ✓ Total charge
  - ✓ Amount in question
  - ✓ Primary/secondary ID numbers
  - ✓ Reason for credit balance
- Excel spreadsheet/communications log reflecting follow-up activity
- Contact person

A sample of a credit balance spreadsheet appears on the next page.

Institutional Provider Relations will:

- Research the account
- Initiate adjustments
- Report the results to the provider

Go to Table of Contents

Credit Balance Audits

Sample Credit Balance Spreadsheet

Patient Name/ Acct #	ID # Primary/ Secondary	Date of Service	Total Charge	Credit Balance on Account	Reason for Credit Balance	Follow-up Tracking
A. Smith	555555555	2/1-2/29/02	$1,200.00	$1,200.00	Duplicate Payment	3/10-Called BC to verify payment
B. Jones	666666666	2/12-2/13/02	$525.00	$420.00	Paid Primary instead of Secondary	3/28-Requested Primary RA
C. Myers	777777777	4/28-5/1/02	$800.00	$800.00		6/1-Researching reason for overpayment
D. Adams	888888888	5/12-5/15/02	$1,500.00	$426.82	Both plans reporting primary	6/3-Called BC-they are contacting other plan