



Complementary To Medicare

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I. Plan 65

Plan 65 is a contract offered to persons AGE 65 or OVER and provides coverage complementary to the Medicare program.

Plan 65 Benefit Options

Individuals select one of eight different benefit options. These options are designed to comply with National Association of Insurance Commissioners' regulations governing Medigap policies.

These options are:

- | | |
|--------|---------------|
| Plan A | Plan A Select |
| Plan C | Plan C Select |
| Plan F | Plan F Select |
| Plan K | Plan K Select |

PLAN 65 ID CARDS

Plan 65 identification cards will reflect the benefit option the member is enrolled in. The identification card will reflect an alpha prefix of XSM.

2009 Plan 65/Plan 65 Select ID Cards

Plan 65 - Medigap Plan A

	BlueCross BlueShield of Kansas	Plan65 Network
Jane A Doe Member Identification Number XSM123456789		
Health Individual		
Group No.	15050	
Plan Code	650/150	
Card Print Date	01/01/2009	
Benefit Plan Medigap Plan A		

	BlueCross BlueShield of Kansas	www.bcbks.com
<small>Members: See your contract for covered services. Possession of this card does not guarantee eligibility for benefits.</small>		
Customer Service: 785-291-4182 1-800-648-1756		
<small>Hospitals or physicians: File claims with your local Blue Cross and/or Blue Shield Plan.</small>		
Blue Cross and Blue Shield of Kansas 1133 S.W. Topeka Boulevard Topeka, Kansas 66629-0001 An Independent Licensee of the Blue Cross and Blue Shield Association.		

Plan 65 Select - Medigap Plan A

	BlueCross BlueShield of Kansas	Plan65Select Network
Jane A Doe Member Identification Number XSM123456789		
Health Individual		
Group No.	15050	
Plan Code	650/150	
Card Print Date	01/01/2009	
Benefit Plan Medigap Plan A		

	BlueCross BlueShield of Kansas	www.bcbks.com
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PLAN 65 COVERAGE

The following outlines each Plan 65 benefit option. (Updated for 2009)

Providers are encouraged to contact Customer Services for details regarding benefits at 1-800-432-3990.

- Plan A – This option **does not** cover the Medicare Part A deductible through the first 60 days. Beginning with the 61st day it will pay the Part A deductible.

The member is responsible for the Medicare Part B deductible. Once the Part B deductible is met, this option will cover the remaining coinsurance after Medicare.

- Plan C – This option **does** cover the Medicare Part A deductible.

The member is responsible for the Medicare Part B deductible. Once the Part B deductible is met, this option will cover the remaining coinsurance after Medicare.

- Plan F – This option **does** cover the Medicare Part A and Part B deductible. Once the Part B deductible is met, this option will cover the remaining coinsurance after Medicare.

- Plan K – This option is a **50/50 share-pay** plan. This means that BCBSKS and the member share covered services at 50% until the member's out-of-pocket expense reaches the out-of-pocket maximum per calendar year. Once the member's out-of-pocket maximum is met, Plan K pays 100% of eligible Medicare balances.

The member is responsible for the full Medicare Part B deductible and then the 50/50 share-pay begins.

II. Disability Plan

Blue Cross and Blue Shield of Kansas offers four benefit options to complement coverage to the Medicare program for disabled persons UNDER AGE 65. The options are know as:

Disability Benefit Plan A
Disability Benefit Plan C
Disability Benefit Plan F
Disability Benefit Plan K

DISABILITY PLAN ID CARDS

Disability Plan identification cards will reflect the benefit option the member is enrolled in. The identification card will reflect an alpha prefix of XSM.

DISABILITY PLAN COVERAGE

Disability Plan Benefit Options A, C, F and K offer the same benefits as Plan 65 Benefit Options A, C, F and K.

Refer to the previous information for specific benefit information.

III. Medicare Lifetime Reserve Days

- BCBSKS Plan 65/Disability Plan picks up the Medicare coinsurance for Lifetime Reserve Days.

- The patient must exhaust the sixty (60) Medicare Lifetime Reserve Days before further benefits will be paid by Plan 65/Disability Plan. After the Medicare hospital inpatient coverage (including lifetime reserve days) is exhausted, Plan 65 coverage extends coverage for an additional 365 days per lifetime. Coverage of the Medicare Part A eligible expenses for hospitalization is paid at the diagnostic related group (DRG) day outlier per diem or other appropriate standard of payment.

IV. Part B Ancillaries

If a patient with Medicare Part B is an inpatient of a hospital and the stay is not covered by Medicare Part A, certain ancillary services are covered under Part B. Following Medicare billing guidelines, the hospital should submit to Medicare the following inpatient Part B services:

- a. Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
- b. X-ray, radium, and radioactive isotope therapy including materials and services of technicians
- c. Surgical dressings, and splints, casts, and other devices used for the reduction of fractures and dislocations
- d. Implantable prosthetic devices
- e. Leg, arm, back and neck braces and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- f. Physical therapy
- g. Speech pathology services
- h. Occupational therapy
- i. Ambulance (round trip)
- j. Screening mammography services
- k. Screening pap smears
- l. Influenza, pneumococcal pneumonia, and hepatitis B vaccines.
- m. Colorectal screening

- n. Bone mass measurements
- o. Diabetes self-management
- p. Prostate screening
- q. Hemophilia clotting factors for hemophilia patients competent to use these factors without supervision;
- r. Immunosuppressive drugs;
- s. Oral anti-cancer drugs;
- t. Oral drug prescribed for use as an acute anti-emetic used as part of an anti-cancer chemotherapeutic regimen; and
- u. Epoetin Alfa (EPO).

NOTE: This list is subject to change by the Medicare program.

V. Extended Hospital Days

For general hospital admissions, Plan 65/Disability Plan extends hospital inpatient care for 365 days per lifetime after Medicare Lifetime Reserve Days have been used. (Charges in a psychiatric hospital are not covered under the 365 lifetime day benefit.)

Blue Cross and Blue Shield of Kansas Billing for Additional 365 Lifetime Plan 65/Disability Plan Days

Once Medicare inpatient benefits are exhausted, Plan 65/Disability allows coverage for an additional 365 days. These additional days are allowed once per lifetime.

When billing for these additional days:

- Report BCBSKS as the primary payer.
- The inpatient claim would show a FROM service date of the first day after Medicare benefits are exhausted.
- Indicate in REMARKS the date that Medicare benefits were exhausted.
- Copy of the UB-04 Medicare Inquiry Screen (FISS system).
- If the patient has Medicare Part B, the covered inpatient Part B ancillary charges should be submitted to Medicare

for payment. Plan 65/Disability Plan will pay these ancillary charges secondary to Medicare.

- If the patient does not have Medicare Part B, this information needs to be indicated in the REMARKS (form locator 80) section of the inpatient claim. When there is no Part B, all the ancillary charges should be included on the inpatient claim.
- If private room is to be covered in full, give the medical reason for the private room as reflected in the physician's order. Report this in REMARKS.

Note: If medical necessity for the private room is established during Medicare benefits and the patient remains in a private room during the additional Plan 65/Disability Plan benefit days, no additional statement is necessary.

If the medical need for a private room is established during the additional BCBSKS benefit period, the medical reason for a private must be given as described in the physician's orders.

VI. Plan 65 Select

Plan 65 Select is a Medigap product marketed by BCBSKS in select Kansas counties.

Members selecting this coverage have complementary-to-Medicare benefits similar to our regular Plan 65 coverage's (Plan C, F or K), except they should use a Plan 65 Select network hospital for inpatient care.

NOTE: Failure to use a Plan 65 Select network hospital results in no payment of the deductible. The deductible will be the patient's responsibility.

Providers should call Customer Service for complete benefit information at 1-800-432-3990.

VII. Medicare Exclusion Rider

Medicare Exclusion Rider coverage is chosen by some groups for retired employees age 65 and over or disabled. This type of complementary-to-Medicare contract, combined with Medicare benefits, will bring the overall level of benefits up to the level of coverage the member was entitled to under BCBSKS before Medicare became effective.

A. IDENTIFICATION

A member who has Medicare Exclusion Rider coverage is issued an identification card identical to other group members who are not eligible for Medicare.

IMPORTANT NOTE – Medicare Exclusion Rider benefits will NOT be provided for the balances left after Medicare payment unless the service provided is a covered service under the BCBSKS contract in which the patient is enrolled, even though it may be a covered service under Medicare.

B. ADDITIONAL DAYS AVAILABLE UNDER MEDICARE EXCLUSION CONTRACT

The patient enrolled in a Medicare Exclusion contract is entitled to the same number of BCBSKS days provided those in the group who are under age 65, MINUS any Medicare benefits.

Inpatient benefits available to a Medicare Exclusion Rider member. (Assume this is a BCBSKS contract with 120 days of benefits for this example.):

- Days - 1st THROUGH 90th MEDICARE DAY

1st-60th Picks up Medicare inpatient deductible (less any applicable BCBSKS deductible or

coinsurance). The first 60 days DO NOT count against 120 BCBSKS days.

61st-90th Picks up Medicare coinsurance (less any applicable BCBSKS deductible and coinsurance). Count 30 days against 120 BCBSKS days.

- 91st THROUGH 180th MEDICARE DAY
 - a. Patient elects NOT to use Lifetime Reserve Days –

Follow billing instructions as described earlier in this section using the UB-04/8371 claim form. The 90 days from the 91st through the 180th day are counted against the patient's 120 BCBSKS days are then exhausted. The patient still has 60 Medicare lifetime reserve days available.

- b. Patient elects to USE Lifetime Reserve Days –

- Medicare Exclusion contract picks up Lifetime Reserve coinsurance for 60 days, (less applicable BCBSKS deductible or coinsurance).
 - An additional 30 BCBSKS days are available, MINUS any non-covered charges; BCBSKS days are then exhausted.
 - No BCBSKS payment will be made until the first day following the threshold of the patient's admission during which he exhausts his Lifetime Reserve Days.
 - Beginning on the first day of care following the date of Medicare threshold, charges for the remaining services (i.e. room, supplies, etc.)

should be billed on the UB-04/837I claim form.

C. OUTPATIENT BENEFITS

Outpatient charges are first billed to Medicare.

If the patient does NOT have Part B of Medicare, submit your charges to BCBSKS. Include “Remarks” stating “No Part B” and the Medicare HI Number. BCBSKS will pick up the equivalent of the Part B deductible and/or coinsurance **only**.

IMPORTANT NOTE – The Medicare deductible and/or coinsurance amounts will be picked up only on the services, which would have been eligible under the contract had Medicare NOT been involved. Exclusion Rider payments will be subject to any BCBSKS shared payment, coinsurance, or deductible of the BCBSKS contract. A basic BCBSKS deductible will be taken on each admission.

VIII. Medicare Crossover

In March 2006 Blue Cross and Blue Shield of Kansas converted to the new Medicare consolidated claim crossover process. Under this program, the national Medicare Coordination of Benefits Contractor (COBC) automatically forwards payment information about most Medicare claims to the secondary payer, eliminating the need for providers to separately bill the secondary payer.

How to submit Medicare primary/Blue Plan secondary claims

For members with Medicare primary and Blue Plan secondary coverage,

- Submit claims to your Medicare intermediary or carrier
- On the Medicare claim, be sure to enter the correct Blue Plan name as the secondary payer. This may not be

BCBSKS and you can verify the plan name by checking the member's ID card.

- Report the member's BCBS identification number including the alpha prefix. The alpha prefix appears in the first three positions of the ID number and is critical in confirming the member's coverage.

When you receive the Medicare remittance advice, look to see if the claim was automatically crossed over.

- If the Medicare RA indicates that the claim crossed over, the provider does not need to resubmit the claim.
- If the Medicare RA indicates that the claim did not crossover, providers will need to wait 15 days **AFTER** the Medicare payment/non payment date before submitting an electronic or paper claim to BCBSKS for processing. After the 15 days, submit the claim to BCBSKS with the Medicare remittance advice. (All claims for any Blue Plan member should be sent to BCBSKS).

NOTE: There may be times when the Medicare RA shows the claim crossed over but actually didn't. When this happens, Medicare will send a separate notice showing the internal/document control number, HIC number, medical record number, patient control number, beneficiary name, date of service, the date the claim was processed and will state: "The above claims(s) was/were not crossed over to the patient's supplemental insurer due to a claim data errors". If this occurs, submit the claim to BCBSKS with the Medicare remittance advice.

When should I resubmit?

If you submitted a Medicare claim and haven't received a response,

- Don't automatically submit another claim.
- Check the online Medicare claim system to determine when Medicare paid.
- Use the BCBSKS Web site to check the status of the crossover claim.

Blue Cross and Blue Shield of Kansas (BCBSKS) providers will need to wait 15 days **AFTER** the Medicare payment/non payment date before submitting an electronic or paper claim to BCBSKS for processing. To assist the provider in complying, Electronic Data Interchange (EDI) has implement edits. You will receive an error if you submit the claim prior to waiting 15 days.

If a Medicare secondary payer claim does need to be submitted, an **electronically submitted** claim must reflect:

- the Medicare Adjudication Date in 2330B with a 573 qualifier,
AND
the Medicare Adjudication Date must be equal to or greater than 15 days than the claim filing date.
- While the Medicare ICN in the 2300 NTE with ADD qualifier is not required, we encourage providers to submit this information

Some provider systems automatically create or release a claim to be submitted once the Medicare payment/non payment is posted. If this applies to you, please contact your software vendor and direct them to create or release BCBSKS secondary to Medicare claims only if payment/non payment has occurred 15 days **after** the Medicare claim information has been posted. This will help you ensure that you are following these guidelines.

For more detailed information from Electronic Data Interchange (EDI) regarding electronic claim submission, visit their Web site by clicking on the link below.

<http://www.bcbsks.com/CustomerService/Providers/EDI/index.htm>

How soon will the Blue Plan pay crossover claims?

The COBC will cross over claim information to secondary payers **AFTER** Medicare pays the claim. (This includes satisfying the Medicare claim payment floor.) It may then take an additional 14-30 business days for providers to receive payment from the Blue Plan.

If I have questions, whom do I call?

After checking the status of the claim on the BCBSKS Web site, if you still have questions, call:

BCBSKS customer service center 1-800-432-3990

Learn more about the CMS Crossover Process

- Medlearn Matters [SE0504](#) CMS Consolidation of the Claims Crossover Process
- Medlearn Matters [MM3709](#) Coordination of Benefits Agreement Detailed Error Report Notification Process

IX. How To Request An Update To The BCBSKS Eligibility File

If everything works like it should, after Medicare processes a claim if the patient has BCBSKS as their secondary payer, the information should automatically crossover to BCBSKS so that we can process the eligible balances.

Sometimes this doesn't happen and part of the reason is because BCBSKS does not have the patient identified on the eligibility file that we send to Medicare. Providers can help us correct this problem.

When you identify accounts that didn't automatically crossover, you can:

- Contact the BCBSKS customer service center and ask them to verify the information that's loaded on the eligibility file that we send to Medicare. Be prepared to furnish customer service with:
 - Medicare health insurance (HI) number,
 - Medicare effective dates (Part A & B)

Contact the BCBSKS Customer Service Center at:

Topeka Local (785) 291-4182
Toll free 1-800-648-1756

- Send to BCBSKS a copy of the third screen of the provider CWF file from the Medicare FISS system. This screen shows the Medicare health insurance number as well as the Part A & B effective dates. Be sure to include the BCBSKS ID number along with a note that says “Update Crossover File”. You can fax this information to:

BCBSKS customer service center 785-290-0711

X How To Submit A Paper Request To BCBSKS For Payment Of Medicare Balances

If a provider needs to submit a PAPER request to BCBSKS for the payment of Medicare balances, here’s what you need to do:

- Before submitting a paper claim, please use the claim status section of the BCBSKS Web site (www.bcbsks.com) to see if the claim has already been processed.
- BCBSKS claim status information is secure information and requires the user to establish a provider profile. To learn more about Using Secured Services including how to establish a provider profile, visit our Web site at http://www.bcbsks.com/providers/using_secured_serv.htm
- Send a copy of the Medicare remittance advice 15 days **AFTER** the Medicare payment/non payment date that clearly reflects:
 - Provider name and address
 - NPI used to file the claim to Medicare
- On the Medicare remittance advice, circle or bracket the payment information that needs to be processed (limited to one request per page).

- If you have multiple payments or patients on the same page of the remittance advice that need to be processed by BCBSKS, you will need to duplicate that page and submit a separate copy for EACH case that needs handled.
- Make sure the patient's name and BCBSKS identification number is reflected on the remittance advice.
- Circle the deductible/coinsurance fields on the Medicare remittance advice.
- Include a copy of a UB-04/837I claim form (or identifiable facsimile) that reflects the codes and charges billed to Medicare.

NOTE FOR RHCs: Rural health clinics can include either a UB-04/837I claim form (or identifiable facsimile) or a CMS 1500 claim form that reflects the codes and charges billed to Medicare. Be sure that the claim submitted reflects the NPI billed to Medicare.