How to Work with the Blue Cross VT Teams

BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.
bluecrossvt.org

Operational Reminders

Note: a future edition of our eNewsletter will contain Administrative Reminders

Claim Submission: Must be filed within 180 days of service being rendered. Status inquiries should not be made on new claim submissions until a 30-day timeframe has passed. If there is a need to do a status inquiry prior to the 30 days, it should be done through the Provider Resource Center (PRC). Calls should not be placed to customer service teams unless it has been 30 days or more or, if there is a question regarding the information appearing on the website.

Medicare Crossover Claims for Blue Cross VT secondary (including Federal Employee Program (FEP*) or supplement policies: these will automatically cross over from Medicare and the Medicare explanation will reflect the claims have been crossed over. You need to allow 30 days from the date Medicare forwarded before checking the status of claims or resubmitting. Claim status can be reviewed on the PRC at any time.

*FEP members with Medicare Primary, Medicare will only cross the claims to Blue Cross VT if the member resides in Vermont. If a member is not located in Vermont, but has services in Vermont, providers need to submit the claim to Blue Cross VT for processing.

Medicare Crossover Claims for BlueCard members: these will automatically cross over from Medicare to the members Blue Plan (not Blue Cross VT) and the Medicare explanation will reflect the claim have been crossed over. You need to allow at least 30 days from the date Medicare forwarded before checking the status of claims. If a resubmission is required, it can be sent to the members Blue Plan directly or to Blue Cross VT.

Blue Cross VT Member Claim Appeal: An appeal may only be filed by a provider on behalf of a member when there has been a denial of benefit-related services for reasons such as: non-covered services pursuant to the Member Certificate; services are not medically necessary or investigational; lack of eligibility; reduction of benefits (not a claim editing reduction); or unlisted procedure, service or supply codes that have been through a review and denied.

Before a provider-on-behalf-of-member appeal is submitted, we recommend you contact our customer service team, as most issues can be resolved without an appeal. If you proceed with an appeal, there are three levels to the Provider-on-Behalf-of-Member Appeal process. Please see our on-line Provider Handbook, Section 6 for full details.

When submitting an appeal request, you must include the member's name, date of birth, member policy identification number (ID number), date(s) of service, charge amount of the claim, and any clinical

prior to the procedure that supports the medical necessity of the procedure (not just the results of the procedure).

Note: Denials for (1) lack of prior approval, (2) duplicate claims, (3) timely filing, (4) claim edits (such as inclusive, mutually exclusive), (5) application of payment policies and (6) unlisted procedure, service or supply codes that have denied for a lack of description or documentation (see our on-line Provider Handbook, Section 6.7 Claim Specific Guidelines under "Unlisted Procedures, Services or Supply Codes for details) cannot be appealed, per our provider contracts. Do not file appeals for these denials.

BlueCard® Member Claim Appeal: Appeals for all BlueCard® claims are handled through Blue Cross VT. We coordinate the appeal process with the member's Blue Plan. There is a specific form for BlueCard® appeals on our provider website under Provider Forms & Resources, on the Claim Forms and Information link under BlueCard Appeal Form, that must be completed and sent with all BlueCard® appeals.

Reminders:

- A BlueCard appeal form should only be used when there is a confirmed denial of benefits
- Timely filing denials are not appealable and CANNOT be submitted on an appeal form.
    - If you would like timely filing reviewed – attach documentation supporting timely filing to a payment inquiry form and send by email to bluecard@bcbsvt.com
- Some Blue Plans may require members to sign an additional form specific to their Plan before they will start an appeal process.

Corrected Claim – A corrected claim is one which has processed **through to an 835/provider voucher** and needs a **specific correction to information in a specific form locator**. Full details of how to submit and full description of a corrected claim is available in our on-line Provider Handbook, Section 6.1 under Adjustments/Corrected claims.

Provider Inquiries – Most of your questions can be answered by using the Provider Resource Center (eligibility, benefits, claims status, copies of provider vouchers, etc), or by using the public Bluecrossvt.org/provider area (prior approval lists, medical and payment policies, etc). If you would like to learn more about this and see how it can decrease your administrative time, please contact provider relations at (888) 449-0443 option 1.

However, if you are not able to find your answer using our web resources, we have dedicated customer service teams specializing in provider issues that are available to you by email or phone. To ensure your inquiry is directed to the correct department, please see the grid located at https://www.bluecrossvt.org/providers under Provider Forms and Resources, Additional Resources, Contact Information for Providers.

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We generally respond to emails within 30 business days. The phone lines are open weekdays from 7 a.m. until 6 p.m., or for the Federal Employee Program 8 am to 4:30 pm. Note: BlueCard® email inquiries will get an email status within 5 business days but can take up to 90 days to resolve.

Please have the following information available when you email* or call:

- Your National Provider Identifier(s).
- Your patient's name, identification number, including the alpha prefix, date of birth and date of service (if applicable)

*Email is recommended as our phone hold times may be long. When emailing, please include the billing NPI number, member name, member identification number, member date of birth and date(s) of service to reduce the overall response time. Please note, all emails sent by Blue Cross VT are secure and HIPAA compliant.

CustomerService@bcbsvt.com for Blue Cross VT

FEPCustomerService@bcbsvt.com for Federal Employee Program

Bluecard@bcbsvt.com for BlueCard® (including New England Health Plan and Access Blue New England)

NOTE: Medicare Advantage claims including those for Vermont Blue Advantage members are handled by Vermont Blue Advantage provider services team by phone at (844) 839-5122. Do not contact Blue Cross VT.