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This manual is intended to be used as a practical and informational guide. In the event of a conflict or inconsistency between the Regulatory requirement and this manual, the provisions of the regulatory requirements will control, except with regard to benefit contracts outside the scope of the regulatory requirement.
I. Introduction

This BlueCare Plus HMO D-SNP (BlueCare Plus) Provider Administration Manual contains comprehensive information regarding D-SNP operating policies and procedures. The information contained in this Manual applies to providers who care for BlueCare Plus members.

BlueCare Plus provides fully integrated health care including prescription drug coverage and behavioral health services for members.

The requirements, policies and processes defined in this Provider Administration Manual (PAM) are a contractual obligation as stipulated in either the stand-alone BlueCare Plus Agreement or a BlueCare Plus Amendment to the BlueCare /TennCareSelect Agreements.

Changes to this Manual will be communicated to providers at least thirty (30) days prior to implementation (excludes medical policy changes driven by new technology). Such changes will be communicated using one or more of the following resources:

- BlueAlert Monthly Provider Newsletter
- Quarterly Provider Manual updates
- Individual Provider Mailings

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by BlueCross BlueShield of Tennessee (BCBST), including its licensed affiliate, BlueCare Plus.

Furthermore, no person shall be subjected to any form of retaliation to include, threats, coercion, intimidation or discrimination because of filing a complaint, testifying, assisting or participating in an investigation, proceeding or hearing.

A. BlueCare Plus Statement of Purpose

BUSINESS
Our Business is financing affordable health care coverage.

PURPOSE
Local Solutions, Meaningful Results.

LONG-TERM CORPORATE GOALS
Our Long-Term Corporate Goals are:

- Affordability

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MISSION

BlueCare Plus is an HMO D-SNP program that works with each member and a team of professionals to offer the most appropriate programs to meet physical, behavioral health, long-term care and social needs ranging from preventive initiatives to care coordination.

BlueCare Plus designs specialized technology and customer care management programs. We rely on an evidence-based model of care and compassion to provide appropriate choices and affordable health care consistent with the needs of our members. Working together with our members, we are able to integrate Medicare and Medicaid benefits in a seamless continuum of care that is focused on the individualized needs of the member.

BlueCare Plus is committed to excellence. Customer service is more than answering questions quickly and correctly. Customer service is the very heart of BlueCare Plus, talking personally, individually, to our members, making sure each member receives the particular services needed. We work as a liaison between members and providers, helping customers access their benefits and assisting providers in coordinating and managing members care.

B. Code of Business Conduct

We have built a bond of trust with the people we serve, as well as the vendors and suppliers with whom we do business.

To strengthen that bond of trust, BlueCare Plus adopted a set of policies and Code of Conduct that applies to all employees, officers, contracted vendors, and members of the Board of Directors. We are willing to share our own Code of Conduct, along with related policies and procedures, with our business partners in order to relay our commitment to a corporate culture of ethics and compliance. The Code of Conduct sets an ethical tone for the organization and provides guidelines for how our business partners and BlueCare Plus is expected to conduct business.

We encourage suppliers and third parties with whom we do business to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent, detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud.

Included in our Code of Conduct are two sections entitled “Conflicts of Interest” and “Dealing with Customers, Suppliers, and Third Parties”. The primary focus of these sections is to help ensure business decisions based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is otherwise incompatible with our
professional responsibilities should be avoided. You may review the Code of Conduct in its entirety online at bluecare.bcbst.com/about-us/.

Please share this information with all your employees who interact with our company. If you should have any questions, or wish to report a suspected violation, please call the Confidential Compliance Hotline, 1-888-343-4221 or e-mail us at compliancehotline@bcbst.com.

**C. Provider Manual Requirements**

BlueCare Plus is required to explain certain categories in the provider manual. A listing of the topics is included below.

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<th>Page #</th>
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1. **Reporting Obligations**

BlueCare Plus must meet the requirements set forth by The Centers for Medicare & Medicaid Services (CMS) by providing information that is necessary for CMS to administer and evaluate the Special Needs Plan (D-SNP) program, in addition to establishing a process for current and prospective members to exercise choice in obtaining Medicare services. Information includes plan quality and performance indicators such as disenrollment rates, information on member satisfaction and information on health outcomes. Network providers must work together with BlueCare Plus in its data reporting obligations by providing any information that it needs to meet its obligations.

2. **Certification of Diagnostic Data**

BlueCare Plus is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member, provider, supplier, physician or any other practitioner. Participating providers that furnish diagnostic data to assist BlueCare Plus in meeting...
its reporting obligations to CMS must certify to the best of their knowledge and information the accuracy, completeness and truthfulness of the data submitted.

**D. Statutory and Regulatory History**

Congress authorized special needs plans (SNPs) as a type of Medicare Advantage (MA) plan designed to enroll members with special needs. The first component of the plan requires an evidence-based model of care with an appropriate network of providers and specialists that meet the needs of the target population.

The second component is an array of care management services that includes: 1) A comprehensive initial assessment and an annual assessment of the members’ individual physical, psychosocial, and functional needs; 2) an individualized Plan of Care (POC) and Interdisciplinary Care Team (ICT).

BlueCare Plus HMO Special Needs Program serves members who are dually eligible for Medicare and Medicaid within the BlueCare Plus service area.

1. **The Medicare Improvements for Patients and Providers Act (MIPPA)**

The Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110–275), enacted on July 05, 2008, called upon the Secretary to revise the marketing requirements for Part C and Part D plans in several areas. MIPPA also enacted changes with respect to Special Needs Plans (SNPs), Private Fee-For-Service plans (PFFS), Quality Improvement Programs, the prompt payment of Part D claims, and the use of Part D data. With the exceptions noted in the final rule, MIPPA required that these new rules take effect at a date specified by the Secretary, but no later than November 15, 2008.

Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the SNP provider to enter into an agreement with the State to provide or arrange for Medicaid benefits to be provided to its Dual Eligible enrollees.

The final rule finalized the MIPPA related provisions of the September 18, 2008 IFC (73 FR 54226), November 14, 2008 IFC (73 FR 67406), November 21, 2008 correction notice (73 FR 70598), and one provision on two SNP-related statutory definitions that was finalized with a comment period in the January 16, 2009 final rule with comment period (74 FR 2881).

2. **Special Needs Plan**

The dually eligible Special Needs Plan (SNP) enrolls members who are entitled to both Medicare (Title XVIII) and Medical Assistance from the State under Title XIX (Medicaid) and offer the opportunity of enhanced benefits by coordinating those available through Medicare and Medicaid. The program is designed to promote the integration and coordination of Medicare and Medicaid benefits through a single managed care organization, while ensuring full access to seamless high quality health care and to make the system as cost effective as possible.
The Affordable Care Act created requirements for D-SNPs:

- Provide dual eligible members access to Medicare and Medicaid benefits under a single managed care organization;
- Coordinate delivery of covered Medicare and Medicaid health and long-term care services;
- Possess a valid capitated contract with the State for specified primary, acute, and long-term care benefits consistent with State policy; and
- Comply with CMS and State policy regarding marketing, appeals, quality assurance, and enrollment communication procedures.

The Affordable Care Act also charged Medicare and Medicaid to establish a better-integrated working relationship with the primary goal of improving patient care and lowering costs.
II. Administrative

A. Enhanced Services Program

**BlueCare Plus**

Development of the Medicare special needs plans are to provide more focused and specialized healthcare for people who require health benefits tailored to their specific needs and conditions. The plans are available to Medicare and Medicaid members who have chronic, severe or disabling medical conditions. BlueCare Plus is a person-centered approach to coordinated care for special needs members. BlueCare Plus is a Medicare-approved special needs plan available to anyone who meets the specific eligibility requirements of the plan, and is enrolled in both Medicare Part A and Part B through age or disability and State Medicaid Plan.

The program promotes quality and cost-effective coordination of care for BlueCare Plus members with chronic, complex, and complicated health care, social service and long-term care needs. Care Coordination involves the systemic process of assessment, planning, coordinating, implementing and evaluating care received through fully integrated physical and behavioral health to ensure the care needs of the member are met.

<table>
<thead>
<tr>
<th>Member Service Line</th>
<th>1-800-332-5762</th>
</tr>
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<tbody>
<tr>
<td>Provider Service Line</td>
<td>1-800-299-1407</td>
</tr>
<tr>
<td>Fax Line</td>
<td>1-800-725-6849</td>
</tr>
<tr>
<td>Prior Authorization for Medical and Behavioral Health</td>
<td>1-866-789-6314</td>
</tr>
<tr>
<td>Prior Authorization for Medical and Behavioral Health Fax</td>
<td>1-866 325-6698</td>
</tr>
</tbody>
</table>

B. General Information

1. **Interpretation Services**

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to BlueCare Plus and it is not permissible to charge a BlueCare Plus member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at [https://www.fhwa.dot.gov/civilrights/programs/tvi.cfm](https://www.fhwa.dot.gov/civilrights/programs/tvi.cfm)

Providers can use the “I Speak” Language Identification Flash Card to identify the primary language of BlueCare Plus members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at [http://www.lep.gov/ISpeakCards2004.pdf](http://www.lep.gov/ISpeakCards2004.pdf).
Additional recommended resources for use when LEP services are needed or providers cannot locate
interpreters specializing in meeting needs of LEP clients may include the following:

- Language Line 1-800-874-9426
- Open Communications International 615-321-5858
- Institute of Foreign Language 615-741-7579

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.

2. Health Literacy and Cultural Competency Provider Tool Kit

Health Literacy and Cultural Competency are important issues facing health care providers. It is
important for organizations to have and utilize policies, trained and skilled employees and resources
to anticipate, recognize and respond to various expectations (language, cultural and religious) of
members and health care providers.

BlueCare Plus through collaborative efforts with the Division of TennCare offers a Health Literacy
and Cultural Competency Provider Tool Kit providing health care professionals additional resources
to better manage Members with diverse backgrounds. The Tool Kit may be accessed on the company

3. Prior Authorization

See the Utilization Management Program section of this Manual for a listing of selected services
requiring prior authorization. Prior Authorization services for physical and behavioral health services
can be arranged by calling or faxing the request to the Utilization Management Department Monday
through Friday, 8 a.m. to 6 p.m. (ET) at one of the statewide telephone numbers listed below:

1-866-789-6314 (option 4)
1-866-325-6698 (fax)

4. Important Contact Information

<table>
<thead>
<tr>
<th>Contact</th>
<th>Toll Free or Local Number</th>
<th>Address or Description</th>
</tr>
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<tbody>
<tr>
<td>Provider Relations:</td>
<td></td>
<td>Provider Relations</td>
</tr>
<tr>
<td>Chattanooga</td>
<td>423-535-6307</td>
<td>1 Cameron Hill Circle,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chattanooga, TN 37402</td>
</tr>
</tbody>
</table>

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Provider Service Line

Eligibility 1-800-299-1407 Available Monday - Friday (except between 7 p.m. and 9 p.m. when eligibility information is being updated) and Saturday and Sunday from 8 a.m. to 4 p.m. The system is not available on Thanksgiving Day or Christmas Day.

Claims Status

Care Management

Health Information and Education 1-888-747-8951 Available 24-hours-a-day, 7-days-a-week

Health Care Counseling 1-800-262-2873

Inpatient/Outpatient Behavioral Health 1-866-789-6314 All inpatient and some specific outpatient behavioral health care services require prior authorization. To arrange behavioral health services.

Pharmacy Program – Prior Authorization 1-800-935-6103

Dental 1-800-332-5762

Enrollment 1-800-924-7141

eBusiness Solutions Technical 423-535-5717

State of Tennessee

Division of TennCare 1-866-311-4287 Division of TennCare

Division of TennCare Program Integrity 1-800-433-3982 To report suspected fraudulent activity.
C. Compliance

1. **Protected Health Information-allowable disclosures under HIPAA**

Privacy of medical information is important to all covered entities. New federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way BlueCare Plus operates, however, it will not prevent us from exchanging the information we need for treatment, payment, and health care operations (TPO).

BlueCare Plus will continue to conduct business as usual in most circumstances. HIPAA regulations allow disclosure of certain medical information, and BlueCare Plus providers (subject to all applicable privacy and confidentiality requirements) are contractually obligated to make medical records of BlueCare Plus members available to each Physician and/or Health Care Professional treating BlueCare Plus, its agents, or representatives.

Privacy Regulations should not affect patient treatment and quality of care; it is vital for the benefit of our members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. The following offers examples of TPO, which include, but are not limited to:

- **Treatment** - rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.
- **Payment** - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a provider for services rendered to a patient.
- **Health care operations** - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.
For complete TPO definitions and a listing of examples, please review the federal regulations at www.hhs.gov/ocr/hipaa/finalreg.html.

If you have any questions or concerns regarding privacy matters, you may contact the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail privacy_office@bcbst.com.

2. **Fraud and Abuse**
   
   A special telephone hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether or not they are a BlueCross BlueShield of Tennessee participating provider or member, can report suspected health care fraud by: calling BlueCross BlueShield of Tennessee Fraud and Abuse Hotline at 1-888-343-4221 or submitting a confidential tip online at www.bcbst.com/fraud/index.page.

3. **False Claims Act**
   
   The following information pertains to the Federal False Claims Act (Title 31, Section 3729):

   **Civil Liability for Certain Acts.** — A person is liable under the Federal False Claims Act, who—
   
   - Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
   - Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
   - Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
   - Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
   - Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
   - Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

   **Civil Penalties and Damages**
   
   - Civil penalty of not less than $5,000 and not more than $10,000,
   - Cost of litigation; and
   - Damages of 3 times the amount of damages which the Government sustains because of the act of that person, except that the court may assess not less than 2 times the amount of damages which the Government sustains if the court finds that:
     - The person committing the violation furnished officials of the United States responsible for investigating false claims violations with all information known to such person
about the violation within 30 days after the date on which the person (defendant) first obtained the information;

- The person fully cooperated with any Government investigation of the violation; and
- At the time the person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under Title 31 of the United States Code with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation;

Whistleblower

- Whistleblower provision
  - Individuals with original information regarding fraud involving government health care programs may file a lawsuit.
  - As used in this section, Whistleblower – means an employee who discloses suspected fraud or abuse by his/her employer to a government or law enforcement agency.
- Whistleblower successful lawsuit
  - Must meet specific legal requirements.
  - Possibly awarded 15 percent to 30 percent of total recovered.
  - Employee protected from retaliation.
- Whistleblower protection from retaliation
  - Employee must reasonably believe he/she is reporting a violation of the law.
  - Employer cannot discharge, demote, suspend, harass, or in any manner discriminate against the employee whistleblowing.
- Employer Liability for Retaliation Against Whistleblower
  - Reinstatement of job with same seniority status;
  - 2 times back pay, plus interest on back pay;
  - Litigation costs and attorneys’ fees; and
  - Any other special damages sustained by the Whistleblower.

Criminal Liability for Certain Acts.

**Improper Benefits**
A person commits Class E felony who knowingly obtains or attempts to obtain, or aids or abets any person to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, an Improper Benefit. As used in this section, “Improper Benefit” refers to:

- Medical assistance benefits provided pursuant to a TennCare rule, law, or regulation that the person is not entitled to receive or that are of a greater value than the person is authorized to receive;
- Benefits the person receives as a result of knowingly making a false statement or concealing a material fact relating to personal or household income that results in the assessment of a lower monthly premium than the person would be required to pay if not for the false statement or concealment of a material fact; and Controlled substances benefits the person receives
by knowingly, willfully and with the intent to deceive, failing to disclose to a health care provider that the person received the same or similar controlled substance from another practitioner within the previous 30 days and the person used TennCare to pay for either the clinical visit or for the controlled substance.

False Claims
An entity or person (but not an enrollee or applicant) commits a Class D felony who knowingly obtains or attempts to obtain, or aids or abets a person or entity to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, medical assistance payment under TennCare to which the entity or person is not entitled or which are of greater value than that to which the entity or person is entitled.

Misrepresentation of Medical Condition or Eligibility for Insurance.
An entity or person commits a Class D felony who by means of a willfully false statement regarding another person’s medical condition or eligibility for insurance to aid the person in obtaining or attempting to obtain medical assistance payments, benefits or any assistance provided under TennCare to which the person is not entitled or which are of greater value than that to which the person is authorized to receive. (“Attempting to obtain” as used in this section includes knowingly making a false claim.)

Obstruction of Investigation.
Any entity or person commits a Class D felony who in connection with any of the above offenses knowingly and willfully falsifies, conceals or omits by any trick, scheme, artifice, or device a material fact; makes a materially false or fraudulent statement or representation; or makes or uses a materially false writing or document.

Criminal Penalties, Restitution, and Sanctions.
- Criminal felony penalties as described above;
- Restitution to TennCare of the greater of the total amount of all medical assistance payments made to all providers, or a managed care entity, related to the services underlying the offense;
- Disqualify the person from participation in TennCare; and
- Report the person or entity to the appropriate professional licensure board or Department of Commerce and Insurance for disciplinary action.

4. Requirements for Reporting Fraud and Abuse

Persons are encouraged to report suspected fraud and abuse. Persons who have knowledge of fraud and abuse are required to report it as follows:
- **Recipient, Enrollee or Applicant Fraud.** Providers, managed care organizations, and others must notify the Office of TennCare Inspector General immediately when there is actual knowledge of TennCare recipient, enrollee or applicant fraud. Call toll-free 1-800-433-3982 or go online to www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. This obligation does not apply if the knowledge is subject to a testimonial privilege.
- **Provider Fraud.** Providers, managed care organizations, and others must notify the Medicaid Fraud Control Unit immediately when there is actual knowledge of provider fraud. Call toll-free 1-800-433-5454.

- **Failure to Report.** Any person who willfully fails to report fraud shall be subject to a civil penalty of up to $10,000 for each finding of the TennCare Inspector General.

BlueCare Plus will comply with the reporting requirements established by The Centers for Medicare and Medicaid Services (CMS).

5. **Education of Employees, Contractors, and Agents**

**Deficit Reduction Act of 2005**

If provider receives or makes annual Medicaid payments of $5 million or more than meets the definition of a “covered entity” under section 6032 of the Deficit Reduction Act of 2005 and shall provide information/education to employees, contractors, and agents of the provider about false claims recovery including the following components:

1. Provide detailed information in written policies applicable to employees, contractors, and agents of the provider about the federal False Claims Act and any State laws that pertain to civil or criminal penalties for making false claims and statements to the Government or its agents.

2. Provide detailed information about whistleblower protections under such laws, along with the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.

3. These written policies must also include detailed information about the provider’s policies and procedures for detecting and preventing fraud, waste and abuse.

4. The provider’s employee handbook, if the “covered entity” has one, shall include a specific discussion of the laws, the right of employees to be protected as whistleblowers, and the provider’s policies and procedures for detecting and preventing fraud, waste and abuse.

5. The provider shall have documented instructions on how to report suspected fraud including the telephone number and person to contact within the organization. These instructions shall also tell how to report suspected fraud to external agencies such as the State of Tennessee Comptroller’s hot-line (1-800-232-5454), the Tennessee Department of Finance and Administration’s Office of Inspector General (OIG) fraud and abuse hot-line (1-800-433-3982) and the Tennessee Bureau of Investigation (TBI) Medicaid fraud hot-line (1-800-433-5454).

6. The provider shall have procedure to follow up on suspected fraud including how they report the results of their investigation.
6. **Non-Discrimination**

BlueCare Plus participating Providers through their contracts with us and in compliance with existing federal and state laws, rules and regulations agree not to discriminate against Members in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

Section 1557 of the Affordable Care Act (ACA) and its implementing regulations (Section 1557) prohibits “covered entities” from discriminating against individuals on the basis of race, color, national origin, sex, age, or disability in any health program or activity. “Covered entities” include health insurance issuers and health care Providers that receive federal financial assistance.

Participating Providers who are ‘covered entities’ as defined in Section 1557 have identified compliance obligations under Section 1557 and must meet those compliance obligations with respect to interactions with and services rendered to BlueCare Plus Members. These include, without limitation, informing Members about non-discrimination and the availability of translation services and information in their own language for Members with limited English proficiency.

Participating Providers should review their respective obligations and the requirements of Section 1557 to ensure their respective compliance. Information about Section 1557 of the ACA and compliance with same is available from the Department of Health and Human Services at www.hhs.gov/civil-rights/for-individuals/section-1557/index.html.

Participating Providers agree to cooperate with reasonable requests from BlueCare Plus and/or the applicable Payer in the investigation of any Member complaints.

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D. **Coordination of Benefits, Medicare Secondary Payer and Third Party Liability**

BlueCare Plus includes the provision for Coordination of Benefits (COB), which applies when a member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary payer prior to submission to BlueCare Plus.

All Medicare secondary payer rules apply. These rules can be found in the *Medicare Secondary Payer Manual* located at www.cms.gov/Manuals/IOM/list.asp. Also at www.cms.gov/Regulations-and-Guidance/GuidanceManuals/Downloads/mc86c04.pdf Providers should identify primary coverage and provide information to BlueCare Plus at the time of billing.

BlueCare Plus does not pay for services when a third party is required to be the primary payer. This section only covers collections related to the BlueCare Plus program and its responsibility to:

- Identify payers that are primary to BlueCare Plus
- Identify the amounts payable by those payers
- Coordinate its benefits to members with the benefits of the primary payers

In some circumstances, a secondary payer status may arise from settlements and other insurance plans. In some cases coverage for a BlueCare Plus member may depend on the following:

- Whether the enrollee entitlement to Medicare is due to of age or disability;
Who is the primary beneficiary of the other insurance plan; or
The size (number of employees) of the sponsoring employer group.

BlueCare Plus may be secondary if the member is 65 years or older and is covered by a Group Health Plan (GHP) as a result of;

• Current employment or
• Employment of a spouse of any age and;
• The employer employs 20 or more employees

When a BlueCare Plus member is disabled and the member is covered by a Large Group Health Plan (LGHP) because of either:

• Current employment or
• A family member’s current employment
• The employer employs 100 or more members

The purpose of Coordination of Benefits (COB) is to avoid duplicate payments for covered services. COB is applied when the member is also eligible for other health insurance. Providers should submit claims for payment to the primary plan first. Any amount payable by BlueCare Plus is governed by the amount paid by the primary plan. Follow the guidelines below for correct billing;

• When BlueCare Plus is primary, submit the claim directly to BlueCare Plus
• When BlueCare Plus is secondary, submit to the primary carrier first. Attach the Explanation of Benefits (EOB) with the claim.

Providers generally request additional insurance information from patients at the point of service. Providers should bill the primary payer first. If the probable existence of other insurance exists for a particular member, as determined by BlueCare Plus, then BlueCare Plus may deny and return claims to the provider, with the instruction that the provider should bill the third party payer first. When denying a claim for other insurance, BlueCare Plus must give the provider other insurance data in order that the provider can appropriately submit the claim to the third party or primary payer.

In some situations, the availability of other insurance may not be identified until the provider claim has been processed and adjudicated. The other insurance can be identified by internal or external sources.

• Providers always have the discretion to refund payments they have received from BlueCare Plus or one of its contractors, in order to pursue payment from the primary insurance. Once a provider has refunded a payment received from BlueCare Plus or one of its contractors, the provider may not resubmit another claim to BlueCare Plus or its contractor for the same service furnished to the same enrollee on the same date.
If BlueCare Plus learns of the availability of primary insurance after it has made payment to the provider, then BlueCare Plus may recover its payment to the provider if all of the following conditions are met. This policy is not intended to affect the ability of BlueCare Plus to recover a duplicate payment when both BlueCare Plus and a third party have paid a claim to the same provider for the same service.

- Less than nine months have passed since the date of service when there is a commercial insurer or Medicare involved;
- Prior to recoupment of its payment, BlueCare Plus notified the provider with a refund request letter that included, at a minimum:
  - Identification of BlueCare Plus payment;
  - The name of the provider;
  - The list of claims or a reference to a remittance advice date;
  - The reason for overpayment (Example: “Another commercial insurance carrier was the primary carrier at the time of service”);
  - The identification and contact information of the insurance carrier who was determined to have been primary at the time of service, together with information about the insurance policy so that the provider can bill the insurance carrier;
  - A time period of at least forty-five (45) calendar days in which the provider may return the BlueCare Plus payment and/or appeal the decision;
  - Information about how and where to file an appeal with BlueCare Plus and
  - A request that the provider submit claims to the other insurance if not already done.

When providers choose to appeal the refund request letter from BlueCare Plus, they are given thirty (30) calendar days in addition to the forty-five (45) initial calendar days stated in the letter to provide sufficient documentation to BlueCare Plus prior to the BlueCare Plus’ recovery of their payment. Providers should include in their appeals a copy of a denial from the primary carrier, if available.

BlueCare Plus has ensured that there is a separate Service Line or Prompt for provider inquiries regarding these recoveries.

BlueCare Plus may not recoup payments made to a provider when COB is discovered unless all of the above criteria have been met. All appeals should be submitted to the address listed below:

BlueCare Plus
Provider Appeals
1 Cameron Hill Circle
Chattanooga, TN 37402

The Centers for Medicare & Medicaid Services does require that sufficient data will be shared between BlueCare Plus and the state to allow for the coordination and/or integration of Medicare and Medicaid benefits.
E. Provider Networks

Participation in BlueCross BlueShield of Tennessee/Volunteer State Health Plan, dba BlueCare Plus (BlueCare Plus) Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in BCBST/BlueCare Plus Provider Networks, or needing to communicate any changes in their practice may call their local Provider Network Manager.

1. Network Participation Criteria

BlueCross BlueShield of Tennessee has established Network Participation Criteria detailing the terms and conditions for participation in all their Provider Networks. These Terms and Conditions will be consistently applied to all Providers regardless of participation status. These Terms and Conditions will apply to any Provider who:

- is a Network Provider;
- is recruited by the Plan;
- requests participation or re-applies for participation;
- re-applies following voluntary or involuntary termination of Provider’s participation;
- has a significant change in practice, or other intervening event or activity, which initiates a re-application and/or reconsideration of the Provider’s current participation status.

2. Changes in Practice

Certain federal and state regulations may require BCBST/BlueCare Plus contracted Providers to timely notify us of any changes to their street address, telephone numbers, office hours, and any other changes that impact availability.

If you have moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice:

- Call the BlueCare Tennessee Provider Service line, 1-800-468-9736, Monday through Thursday, 8 a.m. to 5:15 p.m. (ET). Choose the “touchtone” option or just say “Network Contracts or Credentialing” when prompted, to easily update your information; and

Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure Provider directories utilized by Members contain the most current and correct information about their practice.

The following may require reconsideration for continued participation of a currently contracted Provider, immediate termination of a contracted Provider, review of the initial application by a non-contracted Provider, or re-application for participation by a non-contracted Provider.
The following changes may require reconsideration and/or re-application for participation in a BCBST/BlueCare Plus Provider Network. BCBST and BlueCare Plus reserves the right to interpret and apply these criteria in its sole discretion and judgment. Any Provider adversely affected by BCBST/BlueCare Plus’s application of these criteria will be entitled to the appropriate appeals procedure set forth in the Provider Dispute Resolution Procedure or set forth in this Manual.

**Practitioner**

Including but not limited to:

- Change in practice locations;
- Change in practice specialty;
- Change in ownership;
- Entering into or exiting from a group practice;
- Change in hospital privileges;
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Malpractice claim(s) and/or judgment(s);
- Indictment, arrest, conviction or moral turpitude allegation;
- Adverse or adversarial relationship with BCBST/BlueCare Plus;
- Any material change, which affects the Practitioner’s ability to perform its obligations to Members and/or BCBST/BlueCare Plus;
- Any material change in the information submitted on the pre-application or application.

**Institutional or Ancillary Providers**

Including but not limited to:

- Change in ownership;
- Malpractice claim(s) and/or judgment(s);
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation, or any extraordinary conditions or training mandated by any licensing agency, federal agency, or peer review committee beyond those normal educational requirements for all Providers to maintain a license.
- Adverse or adversarial relationship with BCBST/BlueCare Tennessee;
- Any material change which affects the organization’s ability to perform its obligations to Member(s) and/or BCBST/BlueCare Tennessee;
- Any material change in the information submitted on the pre-application or application.

3. **Providers Denied Participation**
Providers denied participation in a BCBST/BlueCare Plus Provider Network for other than network need, may not be considered for reapplication for a minimum of one (1) year from the date of denial. Providers will be given reason for denial as well as notice when they may reapply to networks as determined by and at the Provider Participation Standards Committee's sole discretion. This requirement may be waived by BCBST/BlueCare Plus in its sole discretion.

4. **Removal of Providers from BCBST/BlueCare Plus Provider Network**

The Provider Participation Standards Committee (PPSC) will review and take action on all requests for removal of Providers from BCBST/BlueCare Plus Provider Networks including, but not limited to, lack of minimum participation standards, no malpractice insurance, aberrant billing practice, pattern of out of network referrals, or Providers that have (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons set forth in the Provider's Agreement. If PPSC determines a Provider falls within any of these termination reasons, a Provider may be immediately terminated from the BCBST/BlueCare Plus Networks or BCBST/BlueCare Plus may refuse participation in any BCBST/BlueCare Plus Networks.

PPSC may also address any contractual breach of contracts that can lead to terminating a network Provider. In either event, Provider shall not be considered, at the discretion of BCBST/BlueCare Plus, for network participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BCBST/BlueCare Plus, unless the charges are dismissed or otherwise resolved in the Provider’s favor.

The PPSC has delegated the responsibility for initiating administrative terminations to the Provider Network Operations (PNO) Department. If the PNO staff confirms all BCBST/BlueCare Plus policies and procedures were followed related to such administrative terminations, notice of termination may be sent without committee review. If the PNO staff determines there are unique circumstances that warrant a committee level review, the termination action will be brought to PPSC. A list of the reasons for administrative termination of a provider’s participation include, without limitation:

- Loss of License
- Medicare/Medicaid or CHIP Sanctions
- Loss of BCBST/BlueCare Tennessee Credentials or failure to complete the BCBST/BlueCare Tennessee Credentialing or Recredentialing process
- Lack of Network Specific Admitting Privileges (or provision of coverage by a BCBST/BlueCare Tennessee participating Provider)
- Lack of Network Specific 24 Hour Coverage
- Retired/Deceased/Moved out of State
- Excluded from participation in the Medicare/Medicaid and/or CHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program
- Advocacy revoked by the Tennessee Medical Foundation
- Lack of Electronic Funds Transfer
- Lack of Paperless Claims Filing
• No Claims Activity Within 12 Consecutive Months (Provider NPI does not appear on claims in previous 12 months)

A quarterly report will be submitted to PPSC reflecting administrative terminations. Providers that are removed from a BCBST Participating Network may reapply in accordance with the Network Participation Criteria or the timeframe set forth in the Provider termination notice.

In those cases where a Provider is removed from all BCBST/BlueCare Plus participating Networks, credentials will be suspended the effective date of contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

5. Provider Termination Appeal Process

Providers, whose network participation has been terminated for cause through the Committee, shall be entitled to due process in accordance with the procedural remedies set forth below:

• All Provider Network Management contract termination for cause notices are communicated to the Provider via certified mail to the last known address, located in the BlueCross BlueShield of Tennessee/BlueCare Plus Providers’ file.
• Termination notices sent to Providers will include instructions on appealing the termination decision.

1. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER
   a. Written Appeal
      i. The Provider may appeal by submitting a written statement of their position within thirty (30) days of the date of the letter of notice to the Provider. The written appeal will be reviewed by the Committee and a written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
   b. Binding Arbitration
      i. After the final decision by BlueCare Plus, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan’s response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.
      ii. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, the claimant forfeits its filing fee and it may not be assessed against BlueCare Plus.
iii. Each party shall be responsible for on-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party’s attorney’s fees.

iv. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider’s participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

v. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BlueCare Tennessee and the Provider will receive notice of any modification through updates to the Provider Manual.

2. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT
   a. Written Appeal
      i. A Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

   b. Binding Arbitration
      i. If the Provider is still not satisfied with the Committee’s decision, they may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section 1.b above.

3. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS
   a. Written Appeal
      A Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

   b. Hearing
      i. Appointment of the Hearing Officer
         The Provider may request a hearing. In that event, the Chairperson of the Committee shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:
            1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
2. May not be in direct economic competition with the Provider requesting the hearing.
3. Must be qualified to evaluate the issues likely to be presented during the hearing.
4. Shall be acting as member of the Committee while performing his or her duties.

ii. Notice of Hearing
The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a description of the basis for the Hearing, including any acts or omissions which the Provider is alleged to have committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law.

iii. Hearing Procedure
The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.
2. The hearing will be recorded by a court reporter
3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.
4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party’s expense, upon reasonable advance notice, at the location where such records are maintained.
5. During the hearing, each party has the right to:
   a. Call witnesses
   b. Cross-examine opposing witnesses
   c. Submit a written statement at the close of the hearings
6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party
shall also receive a copy of the Hearing Officer’s report and recommendation.

iv. Hearing Officer’s Report
The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer’s recommendation, and the basis for that recommendation.

v. Action by the Committee
The Hearing Officer’s report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless a special meeting is called to consider that report. The Committee may accept, modify or reverse the Hearing Officer’s recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee’s deliberations concerning the Hearing Officer’s report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee’s decision is the final internal action by BlueCare Tennessee. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws. This is the final action of BCBST and the Committee will take the appropriate action at the Conclusion of the Committee decision.

vi. Dispute regarding the Decision
Any action based upon or related to the Committee’s decision must be submitted to binding arbitration in accordance with paragraph 1.b above.

6. Participation in BlueCare Plus Networks

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.
<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>DSNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Tennessee/Contiguous Counties</td>
<td>Required</td>
</tr>
<tr>
<td>II. State License</td>
<td></td>
</tr>
<tr>
<td>1. License to practice is Current and Valid</td>
<td>Required</td>
</tr>
<tr>
<td>2. License to practice is Unrestricted as to services performed</td>
<td>Required</td>
</tr>
<tr>
<td>3. If the Provider’s medical license has been revoked, suspended or not renewed (a license “revocation”) by any jurisdiction, for cause, or the Provider has surrendered or agreed to surrender license to avoid such a revocation, Provider will be considered for participation at a minimum of one (1) year after the date that Provider’s license was re-instated, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider maintains licensure.</td>
<td>Required</td>
</tr>
<tr>
<td>III. Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>IV. Accept Terms of Contract</td>
<td>Required</td>
</tr>
<tr>
<td>V. Board Certified/Eligible</td>
<td>Required</td>
</tr>
<tr>
<td>VI. Must be able to meet Credentialing and Re-credentialing Requirements</td>
<td>Required</td>
</tr>
<tr>
<td>VII. Successful Site Evaluation</td>
<td>Required for Primary Care and High Volume Specialists</td>
</tr>
<tr>
<td>Factors reviewed at site visit are: Accessibility/appearance, Risk Management Policies/Procedures, access/availability of medical services, medical records administration, and valid certification for regulated services and personnel.</td>
<td></td>
</tr>
<tr>
<td>VIII. Admitting Privileges</td>
<td></td>
</tr>
<tr>
<td>Maintain admitting privileges (or provision for coverage by a BCBST participating Provider) with a BCBST network hospital*</td>
<td>Required</td>
</tr>
<tr>
<td>IX. Availability Standards</td>
<td></td>
</tr>
<tr>
<td>Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates</td>
<td></td>
</tr>
<tr>
<td>1. Primary Care</td>
<td>No limits to size. Must meet Network Availability Standards</td>
</tr>
</tbody>
</table>
2. Hospital Based

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology (includes CRNAs)</td>
<td>Yes</td>
</tr>
<tr>
<td>Pathology</td>
<td>Yes</td>
</tr>
<tr>
<td>Radiology</td>
<td>Yes</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Yes</td>
</tr>
</tbody>
</table>

3. Specialists

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
</tr>
</thead>
</table>

X. Member Access Standards

1. Agrees to provide care to members within BCBST standards

2. Demonstrates a practice history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards.

2.1 Regular: Routine Examination, TENNderCARE, Preventive Care, Physical Exam

<table>
<thead>
<tr>
<th>Type</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult - Annual;</td>
<td>Required</td>
</tr>
<tr>
<td>Children - According to the American Academy of Pediatrics periodicity schedule</td>
<td></td>
</tr>
</tbody>
</table>

2.2 Prenatal Care:

<table>
<thead>
<tr>
<th>Trimester</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Trimester</td>
<td>Required</td>
</tr>
<tr>
<td>Second Trimester</td>
<td>Required</td>
</tr>
<tr>
<td>2.3 Urgent Care (Adult &amp; Child)</td>
<td>Required</td>
</tr>
<tr>
<td>2.4 Emergency Care (Adult &amp; Child)</td>
<td>Required</td>
</tr>
<tr>
<td>2.5 Specialty Care (Adult &amp; Child)</td>
<td>Required</td>
</tr>
</tbody>
</table>

2.6 Wait Times
1) **Office Wait Time** (including lab and X-ray) ≤ 45 minutes

2) **Member Telephone Call** (during office hours):
   - Urgent < 15 minutes
   - Routine 24 hours

3) **Member Telephone Call** (after office hours):
   - Urgent ≤ 30 minutes
   - Routine ≤ 90 minutes

2.7 7Day/24 Hour Coverage through Par Providers

3. Open Practice No

4. Service Area Definition TN & Contiguous Counties

**XI. Reimbursement**

1. Agrees to the price and reimbursement schedule for the Network Required

2. Agrees to the reimbursement methodology: Required

3. Agrees not to balance bill member Required

4. Delegation Subject to minimum criteria and approval by Delegated Oversight Committee

5. Administrative Services Only (ASO) Available Yes

6. Acceptance of Electronic Funds Transfer (EFT) Required

7. Electronic Claims Submission Required

**XII. Quality Improvement/Utilization Review/Medical Management Program**

1. Cooperate with BCBST QI & UM Programs Required

2. Maintain a QI/UM Plan Required
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.</strong></td>
<td>Demonstrate practice style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices. Required</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Meet BCBST acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency. Required</td>
</tr>
<tr>
<td><strong>XIII. General Provisions</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1.</strong></td>
<td>Meet member satisfaction standards - Based on member complaints, grievances, and satisfaction survey Required</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities Required</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Agree to participate in exclusive arrangements</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>Satisfactory record on fraud and abuse and billing practices Required</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>Practice style which is consistent with current standards of medical delivery Required</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>Prescribing pattern, which is consistent with BCBST’s quality management program. Required</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td>If the Provider’s Drug Enforcement Administration Certificate, Controlled Dangerous Substances Certificate, or any schedules thereof have been revoked, suspended or not renewed (a “revocation”) by any jurisdiction, for cause, or surrendered to avoid imposition of such revocation, Provider shall not be considered for participation at a minimum of one (1) year after the date that Provider was re-issued a certificate or schedule, except as otherwise provided by applicable laws. If such a certificate or schedule revocation action is pending or initiated against a Provider, Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains certification or schedules. Required</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8. <strong>If the Provider has:</strong> (1) been indicted; (2) been convicted of a crime; (3) committed fraud; or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event, Provider will be considered, at the discretion of BCBST for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider’s favor.</td>
<td>Required</td>
</tr>
<tr>
<td>9. <strong>Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), or SCHIP.</strong></td>
<td>Required</td>
</tr>
<tr>
<td>10. <strong>Term of Contract</strong></td>
<td>Minimum 180 Day Termination</td>
</tr>
<tr>
<td>11. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
</tr>
<tr>
<td>12. <strong>Exclusivity Allowed</strong></td>
<td>No</td>
</tr>
<tr>
<td>13. <strong>Defined Service Area</strong></td>
<td>Statewide</td>
</tr>
<tr>
<td>14. <strong>If Provider has established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST’s agreements with that Provider, other Providers, members or other parties. Provider may not be considered for initial or continued participation in BCBST Networks. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST’s prior or pending termination of the Provider’s participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criterion is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient’s medical condition, treatment or coverage (i.e. to &quot;gag&quot; the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST’s Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.</strong></td>
<td>Required</td>
</tr>
<tr>
<td>15. <strong>Provider’s network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process or failure to maintain hospital privileges at a network hospital.</strong></td>
<td>Required</td>
</tr>
</tbody>
</table>
administrative terminations, Provider may reapply upon cure of the
deficiency.

**Minimum Institutional Provider Network Participation Criteria**

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, **Mobile X-ray Labs**, and Sleep Centers.

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>DSNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Tennessee/Contiguous Counties</td>
<td>Required</td>
</tr>
<tr>
<td>II. State License</td>
<td></td>
</tr>
<tr>
<td>1. License is Current and Valid.</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>2. License is Unrestricted as to services performed.</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>3. If the Provider’s license has been revoked, suspended or not renewed (a license “revocation”) by any jurisdiction, for cause, or if the Provider has surrendered license or agreed to surrender license to avoid such a revocation, the Provider will be considered for participation at a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.</td>
<td>Required</td>
</tr>
<tr>
<td>III. Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>IV. Medicare Certification Requirements</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>V. Accreditation Requirements</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>Network Attribute</td>
<td>DSNP</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>VI.</strong> Accept Terms of Contract</td>
<td>Required</td>
</tr>
<tr>
<td><strong>VII.</strong> Meet Credentialing and Recredentialing Requirements</td>
<td>Required</td>
</tr>
<tr>
<td><strong>VII. 1.</strong> Institutional Providers</td>
<td>No limits to size. Must meet Network Availability Standards.</td>
</tr>
<tr>
<td><strong>IX.</strong> Member Access Standards</td>
<td></td>
</tr>
<tr>
<td>1. Agrees to provide care to members within BCBST standards</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers ability to comply with these standards.</td>
<td>Required</td>
</tr>
<tr>
<td>3. Service Area Definition</td>
<td>TN &amp; Contiguous Counties</td>
</tr>
<tr>
<td>4. Hospitals that are contracted in out-of-state counties which are contiguous to Tennessee must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis</td>
<td>Required</td>
</tr>
<tr>
<td><strong>X.</strong> Reimbursement</td>
<td></td>
</tr>
<tr>
<td>1. Agrees to the price and reimbursement schedule for the Network</td>
<td>Required</td>
</tr>
<tr>
<td>2. Agrees to the reimbursement methodology:</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agrees not to balance bill member</td>
<td>Required</td>
</tr>
<tr>
<td>4. Delegation</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
</tr>
<tr>
<td>5. Administrative Services Only (ASO) Available</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Acceptance of Electronic Funds Transfer (EFT)</td>
<td>Required</td>
</tr>
<tr>
<td>7. Electronic Claims Submission</td>
<td>Required</td>
</tr>
<tr>
<td><strong>XI.</strong> Quality Improvement/Utilization Review/Medical Management Program</td>
<td></td>
</tr>
<tr>
<td>1. Cooperate with BCBST QI &amp; UM Programs</td>
<td>Required</td>
</tr>
<tr>
<td>2. Maintain a QI/UM Plan</td>
<td>Required</td>
</tr>
<tr>
<td>Network Attribute</td>
<td>DSNP</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.</td>
<td>Required</td>
</tr>
</tbody>
</table>

**XII. General Provisions**

<table>
<thead>
<tr>
<th>General Provisions</th>
<th>Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agree to participate in exclusive arrangements</td>
<td></td>
</tr>
<tr>
<td>4. Satisfactory record on fraud and abuse and billing practices</td>
<td>Required</td>
</tr>
<tr>
<td>5. Medical Delivery style which is consistent with current standards of medical delivery</td>
<td>Required</td>
</tr>
<tr>
<td>6. Claims filing method</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>7. If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event Provider will be considered, at the discretion of BCBST, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider’s favor.</td>
<td>Required</td>
</tr>
<tr>
<td>8. Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s) or SCHIP.</td>
<td>Required</td>
</tr>
<tr>
<td>9. Term of Contract</td>
<td>See Exhibit B-1</td>
</tr>
<tr>
<td>10. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
</tr>
<tr>
<td>11. Exclusivity Allowed</td>
<td>No</td>
</tr>
<tr>
<td>12. Defined Service Area</td>
<td>Statewide</td>
</tr>
</tbody>
</table>
### Exhibit B-1

**Minimum Institutional Provider Network Participation Criteria**

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>DSNP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State License Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td>TN: Licensed as an Acute Care Facility</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance</td>
</tr>
<tr>
<td></td>
<td>with that state’s licensing law</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>TN: Licensed as an Ambulatory Surgery</td>
</tr>
<tr>
<td></td>
<td>Facility</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance</td>
</tr>
<tr>
<td></td>
<td>with that state’s licensing laws</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility,</td>
<td>TN: Licensed as a Birthing Center</td>
</tr>
<tr>
<td>Birthing Center</td>
<td><strong>Contiguous</strong>: Licensed in accordance</td>
</tr>
<tr>
<td></td>
<td>with that state’s licensing laws</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>TN: Licensed as a Dialysis Center</td>
</tr>
<tr>
<td>Network Attribute</td>
<td>DSNP</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td><strong>TN</strong>: Licensed as an Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td><strong>TN</strong>: Does not license Outpatient Rehabilitation Facilities</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td><strong>TN</strong>: Licensed as a Skilled Nursing Facility</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td><strong>TN</strong>: Does not license Sleep Centers</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td><strong>TN</strong>: Does not license Mobile X-ray Labs</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td><strong>TN</strong>: Licensed as an Ambulatory Surgery Facility</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
</tbody>
</table>

**Accreditation and/or Certification Requirements**

- **Acute Care Hospital**
  - **JC**, **AOA**, **CHAP** or **ACHC**, and Medicare A or State Site Survey
- **Ambulatory Surgical Facility (ASF)**
  - **JC**, **AOA**, **AAAHC**, or **AAAAASF**, and Medicare B
- **Ambulatory Surgical Facility, Birthing Center**
  - **JC**, **AOA**, **CHAP**, **ACHC** or Medicare B
- **Dialysis Center**
  - Medicare A
- **Inpatient Rehabilitation**
  - **JC**, **CARF** or **AOA**, and Medicare A
- **Outpatient Rehabilitation**
  - Medicare A or Mental Health License
- **Skilled Nursing Facility**
  - Medicare A
<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>DSNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep Labs/Centers</td>
<td>AASM and Medicare B</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>CARF or American Academy of Pain Management</td>
</tr>
</tbody>
</table>

**Term of Contract**

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>Term of Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>Annual, 120 days prior to anniversary of effective date</td>
</tr>
</tbody>
</table>

Minimum Ancillary Provider Network Participation Criteria

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.
<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>DSNP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Tennessee/Contiguous Counties</strong></td>
<td>Required</td>
</tr>
<tr>
<td><strong>II. State License</strong></td>
<td></td>
</tr>
<tr>
<td>1. License to practice is Current and Valid</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>2. License to practice is Unrestricted as to services performed.</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>3. If the Provider’s license has been revoked or not renewed (a license “revocation”) by any jurisdiction, for cause, or surrendered to avoid such a revocation, Provider will be considered for participation a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.</td>
<td>Required</td>
</tr>
<tr>
<td><strong>III. Minimum Insurance Requirements</strong></td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td><strong>IV. Medicare Certification Requirements</strong></td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td><strong>V. Accreditation Requirements</strong></td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td><strong>VI. Accept Terms of Contract</strong></td>
<td>Required</td>
</tr>
<tr>
<td><strong>VII. Meet Credentialing and Recredentialing Requirements</strong></td>
<td>Required</td>
</tr>
<tr>
<td><strong>IX. Member Access Standards</strong></td>
<td></td>
</tr>
<tr>
<td>1. Agrees to provide care to members within BCBST standards</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers’ ability to comply with these standards.</td>
<td>Required</td>
</tr>
<tr>
<td>3. Service Area Definition</td>
<td>TN &amp; Contiguous Counties</td>
</tr>
<tr>
<td><strong>X. Reimbursement</strong></td>
<td></td>
</tr>
<tr>
<td>1. Agrees to the price and reimbursement schedule for the Network</td>
<td>Required</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>2.</td>
<td>Agrees to the reimbursement methodology:</td>
</tr>
<tr>
<td>3.</td>
<td>Agrees not to balance bill member</td>
</tr>
<tr>
<td>4.</td>
<td>Delegation</td>
</tr>
<tr>
<td>5.</td>
<td>ASO Available</td>
</tr>
<tr>
<td>6.</td>
<td>Acceptance of Electronic Funds Transfer (EFT)</td>
</tr>
<tr>
<td>7.</td>
<td>Electronic Claims Submission</td>
</tr>
<tr>
<td><strong>XI.</strong></td>
<td>Quality Improvement/Utilization Review/Medical Management Program</td>
</tr>
<tr>
<td>1.</td>
<td>Cooperate with BCBST QI &amp; UM Programs</td>
</tr>
<tr>
<td>2.</td>
<td>Maintain a QI/UM Plan</td>
</tr>
<tr>
<td>3.</td>
<td>Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.</td>
</tr>
<tr>
<td>4.</td>
<td>Agrees to Rapid Response Requirement</td>
</tr>
<tr>
<td><strong>XII.</strong></td>
<td>General Provisions</td>
</tr>
<tr>
<td>1.</td>
<td>Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey</td>
</tr>
<tr>
<td>2.</td>
<td>Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities.</td>
</tr>
<tr>
<td>3.</td>
<td>Agree to participate in exclusive arrangements</td>
</tr>
<tr>
<td>4.</td>
<td>Satisfactory record on fraud and abuse and billing practices</td>
</tr>
<tr>
<td>5.</td>
<td>Medical Delivery style which is consistent with current standards of medical delivery</td>
</tr>
<tr>
<td>6.</td>
<td>Claims filing method</td>
</tr>
<tr>
<td>7.</td>
<td>Must provide all services</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8.</td>
<td>Services must be available in all counties of a CSA (subcontracting permitted)</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>9.</td>
<td>CLIA Certificate</td>
</tr>
<tr>
<td></td>
<td>Required for Independent Labs only</td>
</tr>
<tr>
<td>10.</td>
<td>Valid contract with CAREMARK*</td>
</tr>
<tr>
<td></td>
<td>Required for Home Infusion only</td>
</tr>
<tr>
<td>11.</td>
<td>If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event Provider will be considered, at the discretion of BCBST, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.</td>
</tr>
<tr>
<td></td>
<td>Required</td>
</tr>
<tr>
<td>12.</td>
<td>Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), or SCHIP.</td>
</tr>
<tr>
<td></td>
<td>Required</td>
</tr>
<tr>
<td>13.</td>
<td>Term of Contract</td>
</tr>
<tr>
<td></td>
<td>See Exhibit B-1</td>
</tr>
<tr>
<td>14.</td>
<td>Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
</tr>
<tr>
<td></td>
<td>Required</td>
</tr>
<tr>
<td>15.</td>
<td>Exclusivity Allowed</td>
</tr>
<tr>
<td></td>
<td>No</td>
</tr>
<tr>
<td>16.</td>
<td>Defined Service Area</td>
</tr>
<tr>
<td></td>
<td>Statewide</td>
</tr>
<tr>
<td>17.</td>
<td>Provider has not established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criterion is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to &quot;gag&quot; the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in</td>
</tr>
<tr>
<td></td>
<td>Required</td>
</tr>
</tbody>
</table>
accordance with BCBST’s Provider Dispute Resolution Procedure may be
deemed, however, to constitute an adversarial relationship with BCBST.

18. Provider’s network participation agreement has not been
terminated, for other than administrative reasons, within the past year.
Examples of administrative terminations are failure to complete the
credentialing process. For administrative terminations, Provider may
reapply upon cure of the deficiency.

Exhibit B-1

Minimum Ancillary Provider Network Participation Criteria

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>DSNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>State License Requirements</td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td><strong>TN</strong>: Licensed as a Home Health Provider <strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td><strong>TN</strong>: Licensed as a Home Health Provider <strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td><strong>TN</strong>: Licensed as a Home Infusion Therapy Provider <strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td><strong>TN</strong>: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers <strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td><strong>TN</strong>: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
</tr>
<tr>
<td>Service Type</td>
<td>Requirement</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies</td>
<td>Contiguous: Licensed in accordance with that state’s</td>
</tr>
<tr>
<td>only, e.g., ostomy supplies)</td>
<td>licensing laws</td>
</tr>
<tr>
<td>Hospice</td>
<td>TN: Licensed as a Hospice Provider</td>
</tr>
<tr>
<td><strong>State License Requirements (cont’d)</strong></td>
<td></td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>TN: Licensed as a Medical Laboratory</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s</td>
</tr>
<tr>
<td></td>
<td>licensing laws</td>
</tr>
<tr>
<td><strong>Minimum Insurance Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Comprehensive Insurance (DME Only)</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Product Liability (Breast Prosthesis Only)</td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Medicare Certification Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>Medicare Part A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>non-motorized equipment only, e.g. walker, canes)</td>
<td></td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>only, e.g., ostomy supplies)</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td>Medicare Part A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td><strong>Accreditation Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>JC or CHAP or AAAHC, if applicable</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Agrees to Rapid Response Requirement**

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td></td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td></td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td></td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
<td></td>
</tr>
<tr>
<td>Hospice</td>
<td></td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td></td>
</tr>
</tbody>
</table>

**Claims Filing Method**

<table>
<thead>
<tr>
<th>Service</th>
<th>CMS-1450</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td></td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
</tr>
<tr>
<td>Provider Type</td>
<td>Service Code</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers <em>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</em></td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers <em>(Soft good supplies only, e.g., ostomy supplies)</em></td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Hospice</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>CMS-1500</td>
</tr>
</tbody>
</table>

**Must Provide all Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers <em>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</em></td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers <em>(Soft good supplies only, e.g., ostomy supplies)</em></td>
<td>N/A</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Services must be available in all counties of a CSA *(subcontracting permitted)***

<table>
<thead>
<tr>
<th>Service</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers <em>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</em></td>
<td>N/A</td>
</tr>
</tbody>
</table>
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies) | N/A
---|---
Hospice | N/A
Independent Laboratory | N/A

**Term of Contract**

<table>
<thead>
<tr>
<th>Service</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>180 days</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>180 days</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>180 days</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>180 days</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>180 days</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
<td>180 days</td>
</tr>
<tr>
<td>Hospice</td>
<td>180 days</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>60 days</td>
</tr>
</tbody>
</table>

7. **Provider Identification Number Process**

Before submitting claims to BlueCare Plus, a Provider must request and be assigned an individual provider identification number or contact us to register their National Provider Identifier (NPI). The purpose of this number is to identify the Provider and ensure accurate distribution of payments, remittance advices (Explanation of Payments (EOPs), and 1099 forms. The assigned provider number or NPI in no way signifies that the Provider participates in any or all BlueCross BlueShield of Tennessee/BlueCare Plus networks.

Inquiries regarding the need for a new provider number or to register their NPI should be directed to:

- BlueCare Tennessee Provider Service line, 1-800-468-9736, and say “Contracts” when prompted.

8. **Provider Rights and Responsibilities**

BlueCare Plus Network Providers have a right to:
• Receive information about the managed care organization, its services, and its Members’ rights and responsibilities.
• Be treated with respect and recognition of their dignity and right to privacy.
• Require that Members follow the plans and instructions for care that they have agreed upon with their Providers.
• Be involved in the adoption of clinical practice guidelines.
• Discontinue treatment of a Member with whom the Provider feels he/she cannot establish or maintain a professional relationship in accordance with the Contractor Risk Agreement.
• Specify the functions and/or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional/technical practice.
• Be paid upon receipt of a clean claim properly submitted by the Provider within the required time frames as specified in T.C.A. 56-32-226 and Section 2-9.g. of the Contractor Risk Agreement.

BlueCare Plus Network Providers have the responsibility to:

• Recognize and abide by all applicable state and federal laws, regulations, and guidelines.
• Assist in such reviews including the provision of complete copies of medical records.
• Provide Members and their representatives with access to their medical records.
• Treat Member with respect and recognition of their dignity and right to privacy.
• Allow Member participation in decision-making regarding their health care.
• Discuss Medically Appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage.
• Provide, to the extent possible, information that the managed care organization needs in order to provide quality care and service to Members.
• Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service.
• Serve as a conduit to the Practitioner community regarding the dissemination of quality and other health care information.
• Abide by the accessibility and availability standards as set forth in the Physician Contract or Agreement.
• Provide Covered Services on 24-hour-a-day, 7-days-a-week basis with call coverage through Network BlueCare Plus Practitioners.
• Be capable of providing comprehensive health care services, in accordance with the network adequacy criteria for time/distance/patient volume, to their BlueCare Plus Members. Comprehensive services shall include, but not be limited to:
  o Preventive health services;
  o Primary care services;
  o Home health care services;
  o Practitioner services; and
  o Hospital services, including emergency services.
• Be responsible for supervising or coordinating the provision of initial and primary care to Members; for initiating specialty care; and for monitoring the continuity of Member care services.
F. Provider Credentialing

1. Introduction

BlueCare Plus utilizes the BlueCross BlueShield of Tennessee (BCBST)/BlueCare Tennessee (BCT) Credentialing Program. The BCBST/BCT Credentialing Program is designed around goals that reflect the BCBST/BCT mission, as well as regulatory and accrediting requirements. In order to establish consistent standards for network participation, and to meet regulatory requirements, BCBST/BCT developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST/BCT partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST/BCT Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BCT conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation.

Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST/BCT networks. Major components of the credentialing program include:

- Credentialing Committee
- Policies and Procedures
- Initial Credentialing Process
- Recredentialing Process
- Delegated Credentialing Activities

The Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150. The Committee shall conduct peer review of those cases meeting the Exception Criteria of the Credentialing and Recredentialing of Practitioners policy (and other situations that involve peer review functions) and will evaluate each case individually.

The Committee may, in its discretion, allow credentialing or continued credentialing of certain Practitioners who fall within the exception criteria and deny credentialing or terminate credentials of other Practitioners who also fall within the exception criteria. It shall be within the Committee’s discretion to assess and evaluate the facts of each individual case and determine whether it is in the best interest of BCT Members and BCT for a Practitioner to be credentialed or credentialing continued. In its discretion, the Committee may deny all Practitioners who fall within a certain exception criteria if the Committee determines that the health and welfare of BCT Members could be jeopardized by credentialing such Practitioners or continuing their credentialing. (Credentialing Committee Discretion Policy).
Practitioners or Organizational Providers have the right to review information (received from outside sources excluding peer review protected information) submitted with their application; correct erroneous information within thirty (30) days of receipt of completed application by contacting us at the address, phone number and/or email address listed below; or be informed of the status of their credentialing/crecredentialing application upon request. Inquiries regarding the Credentialing process and/or Credentialing applications should be addressed to the following:

**Mailing Address:**
BlueCross BlueShield of Tennessee  
Attn: Credentialing Department  
1 Cameron Hill Circle – Ste 0007  
Chattanooga, TN 37402-0007

**Telephone Inquiries:**
(Toll Free) 1-800-357-0395  
(Fax) 1-423-535-8357  
(Fax) 1-423-535-6711

**E-mail:** [Credentials@bcbst.com](mailto:Credentials@bcbst.com)

**Note:** For denial/appeal process refer to the Medical Management Corrective Action Plan in Section XI. Quality Improvement Program in this Manual for detailed description of appeal rights.

## 2. Credentialing Application

Credentialing applications are used to uniformly identify and gather specific information for all practitioners and organizational providers that wish to participate with BlueCare Plus. The BlueCare Plus credentialing standards apply to all licensed independent practitioners or practitioner groups who have an independent relationship with BlueCare Plus. The BlueCare Plus credentialing program determines whether practitioners and other health care professionals, licensed by the State and under contract to BlueCare Plus, are qualified to perform their services and meet the minimum requirements defined by the American Accreditation Healthcare Commission (AAHC/URAC), National Committee for Quality Assurance (NCQA) the Centers for Medicare and Medicaid Services (CMS). Verification of all required credentials is imperative.

Once practitioners and organizational providers have completed the credentialing process, they will receive written notification within ten (10) from the BCBST/BCT Credentialing Department.

**Note:** This notification does not guarantee acceptance in BlueCare Plus networks; practitioners and organizational providers are not considered participating in network until they receive an acceptance letter from BlueCross BlueShield Tennessee Contracting Department, generally within 30 days of receiving a completed application.

**CAQH APPLICATIONS SHOULD REFLECT THE FOLLOWING, ALONG WITH THEIR STANDARD REQUIREMENTS TO BE CONSIDERED COMPLETE:**
• Detailed Explanation of any malpractice suit within the last five (5) years (NPDB reports or self-reported)
• Detailed Explanation of any question(s) answered, “Yes” on the application
• Letter of agreement signed by admitting Physician when Practitioner does not have current Hospital Privileges (If applicable)
• Copy of Certificate from Nationally Recognized Accrediting Body -- NP & PA (ANCC, AANP, if applicable)
• Ownership and Disclosure of Interest Statement
• Group Grid
• Other Supporting Documentation sent to Provider from BCT

Letter for NPs and PAs must include:

• The name and address of supervisory Physician;
• Verification the Physician is responsible for the care and treatment rendered;
• Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP as specified in the Rules and Regulations for the State in which they practice;
• Verification that protocol exists and is located at the premises where the NP practices as required by state law; and
• APN License (NP only).

Electronic Funds Transfer (EFT)

• Providers are required to enroll in the EFT process. For enrollment information, Enrollment information is available on the CAQH Solutions website at https://solutions.caqh.org.
• If you completed the Electronic Funds Transfer Information under Section V—Payment Information of the Credentialing Application, please include a VOIED check with the appropriate account number when returning your application.

The applying Provider will receive notification from BlueCare Plus when all documents have been received and the review process has begun. If all necessary documentation is not received within thirty (30) days of the documentation request date, the application will be closed as incomplete. The Provider has the right to correct erroneous information within thirty (30) days of receipt as well as check the status of application at any time during the credentialing/recredentialing process.

If you have any questions or need assistance, contact Provider Service line at 1-800-924-7141 and say “Credentialing and Contracting” when prompted.

3. Credentialing Policies

BlueCare Plus has written policies and procedures for both the initial and re-credentialing process of practitioners and organizational providers. The following policies are subject to change and should
only be referenced as a guideline. Final determination of credentialing status is a decision of the Corporate Credentialing Committee. For specific assistance, please contact your Regional Provider Relations Representative or call the Credentialing Department at 1-800-357-0395.

**Note:** Primary Care Practitioner and OB/GYN office site visits are performed by BCBST/BCT Tennessee within six (6) months of the credentialing event.

### a. Credentialing Process for Medical Practitioners:

The following information is required and/or must be verified for practitioners:

- A current, valid, full, unrestricted license to practice in the state of jurisdiction.
- History of or current license probation will be subject to peer review.
- Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State Law) within the scope of the practitioner’s practice, if applicable.
- Work history for the last five years with documented gaps in employment over 90 days.
- Malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate (Exceptions made for State Employees).
- Clinical privileges in good standing at a licensed facility designated by the practitioner as the primary admitting facility (Any exceptions to this will be determined by the BCBST Credentialing Committee).
- National Practitioner Data Bank (NPDB) report or Claims History Report from all malpractice carriers for the last five (5) years.
- Board certification verification if the practitioner indicates certified on application.
- BlueCare Plus recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), American Dental Association (ADA), and the American Board of Podiatric Surgery (ABPS) for recognized specialty designation.
- Absence of history of federal and/or state sanctions (Medicare, Medicaid, or TennCare).
- Verification of a current, valid, unrestricted state license is sufficient for a practitioner’s degree. Verification of board certification or highest level of education is necessary for specialty designation.
- History of, or criminal conviction or indictment will be subject to peer review.
- Current Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable.
- Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements with a BlueCare Plus credentialed practitioner.
- Statement from applicant regarding:
  - Current or past physical or mental health problems that may affect ability to provide health care;
  - Current or substance use disorder;
  - History of loss of license and or felony convictions;
  - History of loss or limitation of privileges or disciplinary activity; and
  - An attestation to correctness/completeness of the application;
• Office site visit to each potential Primary Care Practitioner’s and OB/GYN’s office including documentation of a structured review of the site and medical record maintenance process;
• Verification that practitioner is physically at the offices where treatment is being rendered and is interacting and overseeing the NP/PA as specified in the Rules and Regulations for the state in which they practice;
• Verification that protocol exists and is located at the premises where NP/PA practices as required by state law.

Specific requirements for specialties listed:

**Acupuncturist**
• Licensed as an Acupuncturist.
• Proof of current diplomat status in acupuncture from NCCAOM and proof of completion of a 3-year post-secondary acupuncture training program or college acupuncture program that is ACAOM accredited.
• DEA certificate not required.
• No call coverage required.
• No hospital privileges required.

**Audiologist/Speech Therapist/Physical Therapist/Occupational Therapist:**
• Current Licensure in State of Tennessee in Specialty will verify education.
• If not practicing in Tennessee, education may be verified by certificate from:
  o American Occupational Therapy Certification Board;
  o American Speech-Language-Hearing Association;
  o Physical Therapist Certificate of Fitness, if applicable; or
  o Verification of highest level of education in specialty requested.
• No call coverage required.
• Clinical privileges not required.
• DEA not required.

**Chiropractors:**
• Clinical privileges not required.
• DEA not required.

**CRNA:**
• If credentialing is required, call coverage and hospital privileges are required.

**Dentist:**
• Minimum and exception criteria apply with the exception of:
  o Clinical privileges not required
  o General Dentists only require schedule 2 & 3 on their DEA
  o Call coverage not required

**Dietician/Nutritionist**
• Minimum and exception criteria apply with the exception of:
  o Licensed as a Dietician/Nutritionist
  o Minimum of a BA degree from an accredited U.S. college or university, with course approved by the American Dietetic Association’s Commission for a Didactic Program in Dietetics.
o Must undergo a 6 to 12 month practice program or internship at a healthcare facility, 
community agency, or food service corporation, or do the equivalent in combination with 
their undergraduate course work.
o Completion of a Commission on Accreditation of Dietetics Education (CADE) accredited 
Didactic Program in Dietetics and pass the national board examination administered by 
the Commission on Dietetic Registration (CDR).
o Clinical privileges not required.
o Call coverage not required.
o DEA certificate not required.

Genetic Counselor

• Minimum and exception criteria apply with the exception of:
o Licensed as a Genetic Counselor.
o Clinical privileges not required.
o Call coverage not required.
o DEA certificate not required.
o Certificate from National Society of Genetic Counselors (NSGC).
o Education must be from one of the 30 accredited universities that offer Genetic 
Counseling.

Health Department Practitioners

• Minimum and exception criteria apply.

Hospital Based (if practicing outside the hospital setting):

• Must be credentialed and all Minimum and Exception Criteria applies.
• Any hospital-based practitioner with additional practice sites are then evaluated and 
credentialed to that site’s highest standard according to the type of practice (i.e., Primary 
Care).

Lactation Specialist

• Minimum and exception criteria apply with the exception of:
o Licensed as a Registered Nurse at a minimum.
o Certification with IBCLC: Global Certification for Lactation Consultant.
o Clinical privileges not required.
o Call coverage not required.
o DEA certificate not required.

Neuropsychologist (Ph.D.):

• Minimum and Exception criteria apply in addition to:
o Clinical privileges not required.
o License must specify “Health Services Provider”.
o Ph. D. degree required.

Nurse Practitioners or Nurse Mid-Wife:

• Minimum and Exception criteria apply in addition to:
o RN License.
o Advanced Practice Nurse (APN) certificate in TN and applicable prescriptive authority 
for contiguous states.
o Certificate of Fitness required for Nurse Practitioners (NP), if applicable.
o If Prescriptive Authority includes a DEA, all schedules must be verified.
Certification most applicable to the nurse specialty from one of the following bodies:

- American Nurses Credentialing Center;
- American Academy of Nurse Practitioners;
- American College of Nurse-Midwives Certification Council;
- National Certification Corporation of Obstetric and Neonatal Nursing Specialties; or
- National Certification Board of Pediatric Nurse Practitioners and Nurses.

Written statement from the BlueCare Plus credentialed practitioner that has a valid oversight specialty who supervises the health care professional. Such statement must include:

- The name and address of the supervising practitioner;
- Verification the practitioner is responsible for the care and treatment rendered by the NP;
- Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP as specified in the Rules and Regulations for the State in which they practice;
- Verification that a protocol exists and is located at the premises where the NP practices as required by state law; and
- If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

- Exclusions
  - Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
  - DEA certificate not required; however, if applicant has DEA certificate it must be verified.

**Optometrist:**

- Minimum and Exception criteria apply in addition to:
  - State license must contain Therapeutic Certification.
  - Hospital privileges are not required.

**Pathologist**

- If credentialing is required, call coverage and hospital privileges are required.

**Physical Therapist/Occupational Therapist**

- Minimum and Exception criteria apply in addition to:
  - Current Licensure in State of Tennessee in Specialty will verify education. If not practicing in Tennessee, education may be verified by certificate from: American Occupational Therapy Certification Board, Physician Therapist Certificate of Fitness, if applicable or Verification of highest level of education in specialty requested.

- Exclusions:
  - No call coverage required.
  - Clinical privileges not required.
  - DEA certificate not required; however, if application has DEA certificate, all schedules must be verified.

**Physician Assistants:**

- Minimum and Exception criteria apply in addition to:
  - Certificate from the National Commission on Certification of Physician Assistants (NCCPA), if applicable.
Written Statement from the BlueCare Plus credentialed practitioner that has a valid PCP specialty who supervises the health care professional. Such statement shall include:
- The name and address of the supervising practitioner;
- Verification that the practitioner is responsible for the care and treatment rendered by Physician Assistant (PA);
- Verification that the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the PA as specified in the Rules and Regulations for the State in which they practice;
- Verification that a protocol exists and is located at the premises where the PA practices as required by state law; and
- If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

- Exclusion:
  - Clinical privileges not required (must have an arrangement with a credentialed practitioner who has clinical privileges at a credentialed hospital facility).
  - DEA not required however, if applicant has DEA, all schedules must be verified.

**Pharmacist - Clinical**
- BCBST/BCT Staff Pharmacists (and PBM Management)
- Minimum and Exception criteria apply in addition to:
  - Collaborative agreement between Pharmacy and Physician
- Exclusion:
  - Clinical privileges not required.
  - Call coverage not required.

**Pharmacist – Disease Management**
- BCBST/BCT Staff Pharmacists (and PBM Management)
- Minimum and Exception criteria apply in addition to:
  - Copy of certificate for successful completion of accredited disease management program(s) if applicable

**Pharmacist – Immunizing**
- BCBST/BCT Staff Pharmacists (and PBM Management)
- Minimum and Exception criteria apply in addition to:
  - Certification of accredited immunizing program.
- Exclusion:
  - Clinical privileges not required.
  - Call coverage not required.

**Podiatrist**
- Minimum and Exception criteria apply in addition to:
  - Clinical privileges not required (unless current privileges are indicated, they will be verified).

**Radiologist**
- If credentialing is required, call coverage and hospital privileges are required.

**Sleep Medicine**
- This specialty is designated only for Medical Doctors and Doctors of Osteopathy.
Speech Language Pathologist

- Minimum and Exception criteria apply in addition to:
  - Certificate of Clinical Competence – Speech Language Pathology (CCC-SLP) from American Speech-Language-Hearing Association (ASHA) – Not Required. However, if applicant has ASHA Certificate, it must be verified. If certificate has expired, certificate must be verified by previous certificate verification.

Urgent Care Physicians

- Minimum and Exception criteria apply (unless acting as a PCP) with the exception of:
  - Clinical privileges.
  - Call coverage.
  - Site visit.

b. Credentialing Process for Behavioral Health Practitioners/Providers:

The following information is the minimum criteria required and/or must be verified for Behavioral Health Practitioners:

- Current, valid, unrestricted state license within the scope of the Practitioner’s practice.
- Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law.) within the scope of the Practitioner’s practice, if applicable.
- Work history for last five (5) years for initial credentialing: Last three (3) years’ work history for recredentialing. Explanation for all lapses of employment exceeding ninety (90) days.
- Proof of malpractice coverage in amounts of not less than $1,000,000 per case and $3,000,000 aggregate.
- National Practitioner Data Bank or Claims History Report from all malpractice carriers for the last five (5) years.
- Clinical privileges in good standing at a facility designated by the Practitioner as the primary admitting facility. If Practitioner does not have clinical privileges, Practitioner must have a coverage arrangement with a BCT credentialed Practitioner/Provider, if applicable to scope of practice.
- Twenty-four (24)-hours-a-day, seven (7)-days-a-week call coverage
- Completed Education or Board certification in all practice specialties.

Specific requirements for specialties listed:

Psychiatrist

- Minimum and exception criteria

Addictionologist (non –Psychiatrist)

- Minimum and Exception criteria apply in addition to:
  - Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.

Addictionologist (Buprenorphine – Based Therapy for medication assisted treatment of substance abuse)

- Minimum and Exception criteria apply in addition to:
  - DEA certificate with additional buprenorphine endorsement.
  - Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.
  - Certified in buprenorphine therapy in the state where practice is to occur.
Psychologist or Psychoanalyst
- Minimum and Exception criteria apply in addition to:
  - DEA certificate not required, verify if applicable.
  - Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university and meet one of the following:
    1. Doctorate degree received from a college or university program on the American Psychological Association (APA) accredited list of counseling psychology or clinical psychology programs, or
    2. Completion of a pre-doctoral APA approved clinical internship at the time of graduation, or
    3. Listed in the National Register of Health Services Providers in Psychology, or
    4. Diplomat of the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories.

Licensed Clinical Social Worker (LCSW)
- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher from a graduate school or social work accredited by the Council on Social Work Education (CSWE).

Professional Counselors/ Mental Health Counselors/ Licensed Substance Use Disorder Treatment Professionals
- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher in mental health discipline.
  - State licensed or certified at the highest level of independent practice in the state where practice is to occur.
  - In states without licensure or certification, provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) OR meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

Marriage & Family Therapist
- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher in a mental health discipline.
  - State licensed or certified at the highest level of independent practice in the state where practice is to occur, OR certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT) OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

Pastoral Counselors
- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher in mental health discipline.
  - Must be licensed as a pastoral counselor and have certificate by the American Association of Pastoral Counselors.

Licensed Senior Psychological Examiner (SPE)
- Minimum and Exception criteria apply in addition to:
  - Master’s degree in Mental Health Counseling.

Employee Assistance Professional (EAP) Counselor
- Minimum and Exception criteria apply in addition to:
  - Certified as a Certified Employee Assistance Professional (CEAP).
Assistant Behavior Analyst (ABA)

- Minimum and Exception criteria apply in addition to:
  - Certified as an Assistant Behavior Analyst (BCaBA) by the Behavioral Analyst Certification Board.
  - Minimum of a Bachelor’s degree from an accredited university
    - Note: Additional TennCare requirements; and
    - Degree must be for a BACB approved institution of higher education having the BACB required coursework and practice experience.

Certified Behavior Analyst (CBA)

- Minimum and Exception criteria apply in addition to:
  - Certified as Board Certified Behavior Analyst-Doctoral (BCBA D) by Behavior Analyst Certification Board (BCBA).
    - Note: Acceptable TennCare equivalents:
      - Currently licensed in the State of Tennessee for the independent practice of psychology, or
      - Currently a Qualified Mental Health Professional licensed in the State of Tennessee with the scope of practice to include behavior analysis; and Credential verification by the Managed Care Organization.
  - Master’s or Doctorate degree from an accredited university that must be conferred in behavior analysis, education or psychology or in a degree program in which the candidate completed a (BACB) approved course sequence.
  - Certified by Behavior Analyst Certification Board (BCBA).

c. Credentialing Process for Behavioral Health Organizational Providers:
The following information is required and/or must be verified for Behavioral Health Organizational Providers:

- Licensed in the state of TN.
- Professional liability coverage of $1,000,000 per case/$3,000,000 aggregate.
- Malpractice claims history for past five (5) years. NPDB reports or self-reported.
- Accreditation by: The Joint Commission, CARF, Council of Accreditation (COA), AOA, HFAP, AAAHC, (DNV GL), CHAP. If not accredited, a site visit review or copy of state site visit.
- Certification from Medicare, Medicaid, TRICARE or state agencies if applicable.
- DEA certificate, if applicable.
- Staff roster for outpatient mental health and/or substance use disorder clinics.

Specific requirements for organization types listed:

Inpatient Detoxification/Inpatient Substance Abuse Disorder Rehabilitation

- Minimum criteria with the exception of:
  - Must have 24 hours/7-days-week skilled nursing staff.
  - Oversight from a Medical Director.
  - Must have an Addictionologist on staff or contracted or Medical Director must have three (3) years’ experience treating patients with substance use disorder.

Inpatient Psychiatric/ Residential Psychiatric or Substance Abuse Disorder

- Minimum criteria with the exception of:
  - 24 hour/7-days-a-week skilled nursing staff.
  - Oversight from a Medical Director.
Crisis Stabilization Unit
- Minimum criteria with the exception of:
  - Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by AOA, TRICARE, CARF or COA.
  - Formal written agreement with TJC accredited provider for emergency psychiatric, substance use disorder, or medical care if not available on site.

Partial Hospitalization (Psychiatric or Substance Abuse Disorder)
- Minimum criteria with the exception of:
  - Must operate 3-5 days per week and at least 4-6 hours per day.
  - Oversight from a Medical Director or licensed Program Director.
  - Must be under the supervision of a Physician.

Intensive Outpatient (Psychiatric or Substance Abuse Disorder)
- Minimum criteria with the exception of:
  - Must have the supervision of a licensed clinician.
  - Must provide services at least three (3) hours per day, 2-4 days per week.

Outpatient Mental Health and/or Substance Abuse Disorder Clinic
- Minimum criteria with the exception of:
  - Must have a governing body and an organized professional staff.
  - Must have, or have a formal contract with, a multi-disciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one licensed masters- or doctoral-level mental health clinician.
  - Must have written credentialing criteria for all clinical staff.
  - All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services.
  - Must receive oversight from a licensed behavioral health professional.

Crisis Stabilization Unit
- Minimum criteria with the exception of:
  - Program must be part of a Joint Commission accredited hospital or health care organization that provides psychiatric services or Program is part of a facility accredited by AOA, TRICARE, or CARF or COA accredits the program itself, as an observation/holding bed program that provides psychiatric services.
  - Program must meet state licensure/certification and Medicaid requirements (as applicable).
  - Program must meet all applicable federal, state and local laws and regulations.
  - Program must attest to a formal written agreement with Joint Commission accredited Provider for emergency psychiatric, substance abuse, and/or medical care if such care is not available on site.
  - Combination of licensed mental health professional, mental health workers, and other appropriate paraprofessional staff.

Community Mental Health Center
- Minimum criteria with the exception of:
  - Licensed as a Mental Health Outpatient Facility.
  - Formal CMS designation.

Behavioral Health Organizational Providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by BCBST/BCT must have their accreditation status verified. In addition, non-accredited organizational
providers must undergo a structured site visit to confirm that they meet BCBST/BCT standards. Standing with state and federal authorities and programs will be verified.

d. Credentialing Process for Medical Organizational Providers:
Obtaining valid/current copies of the following information as submitted with the credentialing application is essential to ensure that decisions are based on the most accurate, current information available. The following types of Organizational Providers require verification of specific requirements to be considered by the Credentialing Committee. The following pages list these requirements:

<table>
<thead>
<tr>
<th>Organizational Type</th>
<th>Requirements</th>
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</table>
| Acute Care Facility | • TN: Licensed as Acute Care Facility  
Other States: Licensed in accordance with that state’s licensing laws  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• DEA certificate, if applicable  
• CLIA certificate, if applicable  
• Medicare Part A (new facilities which have not obtained subject to Committee exception)  
• TJC or AOA or CHAP or AAAHC, (lack of accreditation subject to Committee exception)  
• If not accredited, copy of State Site Survey required  
• Leapfrog Compliance, if available  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application |
| Ambulatory Infusion Center (AIC) | • TN: Licensed as Ambulatory Surgery Facility  
Other States: Licensed in accordance with that state’s licensing laws  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• Medicare Certificate  
• Accredited by BCBST/BCT approved accrediting body as an AIC  
• Medical Director credentialed by BCBST/BCT  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare or TennCare)  
• An attestation to the correctness and completeness of the application |
| Ambulatory Surgical Facility | • TN: Licensed as Ambulatory Surgery Facility  
Other States: Licensed in accordance with that state’s licensing laws  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• CLIA Certificate, if applicable  
• TJC or AOA or CHAP or AAAHC or AAAASF and Medicare Part B with copy of site audit  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application |
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<tr>
<th>Organizational Type</th>
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| **Birthing Centers**        | • TN: Licensed as a Birthing Center  
  Other States: Licensed in accordance with that state’s licensing laws  
  • $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
  • CLIA Certificate, if applicable  
  • TJC or AOA or CHAP or AAAHC or Medicare Part B  
  • General Liability Insurance  
  • History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
  • An attestation to the correctness and completeness of the application |
| **Dialysis Facility**        | • State of Tennessee End Stage Renal Disease (ESRD) Facility License  
  Other States: Licensed in accordance with that state’s licensing laws  
  • Not currently sanctioned by Medicare/Medicaid  
  • $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
  • Medicare Part A Certification  
  • CLIA Certificate  
  • General Liability Insurance  
  • History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
  • An attestation to the correctness and completeness of the application |
| **DME Providers**            | • TN: Licensed as a DME Provider  
  Other States: Licensed in accordance with that state’s licensing laws  
  • Not currently sanctioned by Medicare/Medicaid  
  • $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
  • Medicare Part B required  
  • DEA certificate, if applicable  
  • Pharmacy License, if applicable  
  • TJC or CHAP or AAAHC, or BOC or The Compliance Team or ABC or NBAOS or CARF or HQAA or ACHC required  
  • General Liability Insurance  
  • History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
  • An attestation to the correctness and completeness of the application |
| **Health Department**        | • State Tort Insurance  
  • CLIA Certificate                                                                                                                                                                                      |
| **Home Infusion Therapy Providers** | • TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License)  
  Other States: Licensed in accordance with that state’s licensing laws  
  • Not currently sanctioned by Medicare/Medicaid  
  • $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
  • Medicare Part B  
  • DEA certificate, if applicable  
  • TJC or CHAP or AAAHC, collect but not required  
  • General Liability Insurance  
  • History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
  • An attestation to the correctness and completeness of the application |
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<tr>
<th>Organizational Type</th>
<th>Requirements</th>
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</table>
| **Home Health Providers**           | • TN: Licensed as a Home Health Provider  
• Other States: Licensed in accordance with that state’s licensing laws  
• Not currently sanctioned by Medicare/Medicaid  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• Medicare Part A  
• CLIA Certificate, if applicable  
• TJC or CHAP or AAAHC, collect but not required  
• If not accredited, copy of state or CMS site audit  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application |
| **Hospice Provider**                | • TN: Licensed as a Hospice Provider  
• Other States: Licensed in accordance with that state’s licensing laws  
• Not currently sanctioned by Medicare/Medicaid  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• Medicare Part A  
• CLIA Certificate, if applicable  
• TJC or AOA or CHAP or AAAHC, collect but not required  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application |
| **Independent Lab**                 | • TN: Licensed as a Laboratory  
• Other States: Licensed in accordance with that state’s licensing law.  
• Not currently sanctioned by Medicare/Medicaid  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• History of Professional liability claims that resulted in settlements or judgments  
• Medicare Part B  
• TJC or CAP, collect if applicable but not required  
• CLIA Certificate, Draw station – CLIA not required  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application |
| **Inpatient Rehabilitation Facility**| • TN: Licensed as a Inpatient Rehabilitation Facility  
• Other States: Licensed in accordance with that state’s licensing laws  
• Not currently sanctioned by Medicare/Medicaid  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• Medicare Part A  
• CLIA certificate, if applicable  
• DEA certificate, if applicable  
• TJC or CARF or AOA accreditation (no exception)  
• General Liability Insurance |
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<tr>
<th>Organizational Type</th>
<th>Requirements</th>
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</table>
|Non-Licensed DME Providers (Non-motorized equipment only e.g. walker; canes; crutches) | • History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application  
• Not currently sanctioned by Medicare/Medicaid  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• History of Professional liability claims that resulted in settlements or judgments  
• Medicare Part B  
• TJC or CHAP or AAAHC, if applicable but not required  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application  

Orthotic/Prosthetic Supplier | • American Board for Certification in Orthotics and Prosthetics Accreditation OR Medicare B Certification  
• General Liability Insurance  
• $1 million/$3 million Malpractice (exception for Breast Prosthetic suppliers ONLY to have product liability coverage $500 thousand) and claims history. NPDB reports or self-reported.  
• History of Professional liability claims that resulted in settlements or judgments  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application  

Outpatient Diagnostic | • $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• History of Professional liability claims that resulted in settlements or judgments  
• Medicare Part B Certification  
• General Liability Insurance  
• CLIA certification, if applicable  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application  

Outpatient Rehabilitation Facility | • Not currently sanctioned by Medicare/Medicaid  
• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.  
• History of Professional liability claims that resulted in settlements or judgments  
• Medicare Part A *(If Provider is licensed under the Tennessee Department of Mental Health and Developmental Disabilities and provides services to pediatric patients, evidence of the State License site audit)*  
• TJC or CORF, collect but not required.  
• CLIA required if onsite laboratory.  
• General Liability Insurance  
• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
• An attestation to the correctness and completeness of the application
<table>
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<tr>
<th>Organizational Type</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>Pain Management Center</td>
<td>• TN: Licensed as an Ambulatory Surgical Facility</td>
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<tr>
<td></td>
<td>• Other States: Licensed in accordance with that state’s licensing laws</td>
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<td></td>
<td>• $1 million/$3 million Malpractice and claims history. NPDB reports or self-</td>
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<td>• DEA certificate, if applicable</td>
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<td></td>
<td>• CARF accreditation or American Academy of Pain Management accreditation</td>
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<td></td>
<td>• General Liability Insurance</td>
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<td>• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td>• An attestation to the correctness and completeness of the application</td>
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<tr>
<td>Professional Support Services</td>
<td>• TN: Licensed as a Professional Support Service</td>
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<tr>
<td>Licensure (PSSL)</td>
<td>• $1 million/$2 million Malpractice and claims history. NPDB reports or self-</td>
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<td>• Medicare certificate</td>
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<td></td>
<td>• Member of DIDS (Division of Intellectual Disability Services)</td>
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<td></td>
<td>• History of Medicare/Medicaid sanction – no prior history</td>
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<td>• General Liability</td>
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<td>• An attestation to the correctness and completeness of the application</td>
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<tr>
<td>Skilled Nursing Facility</td>
<td>• TN: Licensed as a Skilled Nursing Facility</td>
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<tr>
<td>(No Swing Beds)</td>
<td>• Other States: Licensed in accordance with that state’s licensing laws</td>
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<td>• Not currently sanctioned by Medicare/Medicaid</td>
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<td></td>
<td>• $1 million/$3 million Malpractice as consistent with TCA 71-5-1412 and</td>
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<td>• claims history. NPDB reports or self-reported.</td>
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<td>• Medicare Part A</td>
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<td>• CLIA, if applicable</td>
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<td>• DEA certificate, if applicable</td>
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<td>• TJC or CHAP or AAAHC or AOA, collect but not required</td>
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<td>• If not accredited, copy of state or CMS site audit</td>
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<td>• General Liability Insurance</td>
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<tr>
<td>Urgent Care Centers</td>
<td>• State Business License</td>
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<td></td>
<td>• Oversight by a Medical Director that is currently credentialed by BCBST/BCT</td>
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<tr>
<td></td>
<td>• Accreditation by Urgent Care Association of America (UCAOA) or a certificate from Certified Urgent Care (CUC) Program</td>
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<td>• $1 million to $3 million Malpractice and claims history. NPDB reports or self-reported.</td>
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### Organizational Type Requirements

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<thead>
<tr>
<th>Sleep Labs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• $1 million/$3 million Malpractice and claims history. NPDB reports or self-reported.</td>
</tr>
<tr>
<td>• Medicare Certification Part B</td>
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<tr>
<td>• Accreditation by American Academy of Sleep Medicine (AASM) or JC</td>
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<tr>
<td>• General Liability Insurance</td>
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<tr>
<td>• History of any professional liability claims that resulted in settlements or judgments</td>
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<tr>
<td>• Medical Director who is a Diplomat of the ABSM</td>
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<tr>
<td>• History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
</tr>
<tr>
<td>• An attestation to the correctness and completeness of the application</td>
</tr>
</tbody>
</table>

### 4. Re-credentialing Process

All Medical and Behavioral Health providers will be re-credentialed at a minimum of every three years. The date of re-credentialing will be based on the date of initial credentialing.

In addition to the information that will be verified by primary or secondary sources, BlueCross BlueShield of Tennessee, or BlueCare Plus will include and consider collected information regarding the participating practitioner’s performance within the health plan, including information collected through the health plan’s quality management program. Re-credentialing will begin approximately three to six months prior to the expiration of the credentialing cycle. Practitioners are sent a letter stating their file will be placed in a recredentialing status and BCT will retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expeditiously with no interruptions in network participation we encourage the Practitioner to visit the CAQH ProView ProView™ website, [https://proview.caqh.org](https://proview.caqh.org), to update their information. For organizational providers, the initial credentialing information must be resubmitted to BCBST/BCT.

Failure to comply with the request may result in immediate disenrollment from the provider network. Credentialing information that is subject to change must be re-verified from primary sources during the re-credentialing process. The provider must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

### 5. Provider Qualifications and Requirements

In order to be paid by BlueCare Plus for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to BlueCare Plus, in accordance with HIPAA requirements.
- Furnish services to a BlueCare Plus member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
• Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
• Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
• Not excluded or sanctioned by The Health and Human Services (HHS) Office of Inspectors General (OIG) excluded and sanctioned provider lists.
• Not be a Federal health care provider, such as a Veterans’ Administration provider, except when providing emergency care.
• Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
• Agree to cooperate with BlueCare Plus to resolve any member grievance involving the provider within the time frame required under Federal law.
• For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices.
• Not charge the member in excess of the cost sharing under any condition, including in the event of plan bankruptcy.

G. Electronic Data Interchange (EDI)

All network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically ensures compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. Additional information regarding electronic claims is available here.

All network providers are required to receive payment by Electronic Funds Transfer (EFT) to remain in compliance with the terms of the Minimum Practitioner Network Participation Criteria. More information regarding Electronic Funds Transfer (EFT) is available here.

BlueCare Plus accepts claims electronically in the ANSI 837 format additional information is available here.

Submission of professional charges are on the CMS-1500/ANSI-837 Professional Transaction and institutional charges on the CMS-UB04 /ANSI-837 Institutional Transaction. Claims data should be complete and filed for all services both covered and non-covered. Billed services for the same patient, same date of service (DOS), same place of service (POS), must be billed on a single claim submission. Claims data is vital to report measurements and statistics needed for the Healthcare Effectiveness Data and Information Set (HEDIS) and URAC requirements.

The start date for determining the timely filing period is the date of service or “From” date on the claim. For institutional claims (Form CMS-1450, the UB-04 and now the 837 I that includes span dates of service (i.e., a “From” and “Through” date span on the claim), the “Through” date on the claim is used for determining the date of service for claims filing timeliness. For professional claims (Form CMS-1500 and 837-P) submitted by physicians and other suppliers that include span dates of
service, the line item “From” date is used for determining the date of service for claims filing timeliness. (This includes DME supplies and rental items.)

BlueCare Plus timely filing period is 1 year from the date of service or, for facilities, within 1 year from the date of discharge.

If the provider has documented evidence the member did not provide BlueCare Plus insurance information, the timely filing provision shall begin with receipt of insurance information, subject to the limitations of the member’s benefit agreement.

**277CA Health Care Claim Acknowledgement Report or CARES Report**

The new electronic claims 277CA Health Care Claim Acknowledgement Report supplies providers with one comprehensive report of all claims received electronically. The provider should maintain this report proof of timely filing. A provider submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox.

To learn more about retrieving your electronic reports, contact eBusiness Solutions at 423-535-5174, Monday through Thursday, 8 a.m. to 5:15 p.m. (ET) and Friday, 9 a.m. to 5:15 p.m. (ET).

Note: Submission dates of claims filed electronically that are not accepted by BlueCare Plus due to transmission errors are not accepted as proof of timely filing.

1. **Filing Electronic Claims**
   
The electronic claims processing system used by BlueCare Plus is in compliance with Federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS). This system is for processing of American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BlueCare Plus business edits are modified to recognize the required ANSI formats. These edits apply to electronic claims.

   **Provider Number/National Provider Identifier (NPI) Number for Electronic Claims:**

   Claims submitted electronically must include the provider’s appropriate individual BlueCare Plus provider number and/or NPI in the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at www.wpc-edi.com/. You may access additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission at http://www.bcbst.com/providers/ecomm.

   **Note:** BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) guidelines for filing the National Provider Identifier (NPI) Number.
2. **Electronic Enrollment and Support**

Enrollment of new providers, changes to existing provider or billing information (address, tax ID, provider number, NPI, name), or any changes of software vendor should be communicated to eBusiness Solutions via the *Provider Electronic Profile* form. The *Provider Electronic Profile* form is available upon request.

Mail *Provider Electronic Profile* forms to:

BlueCross BlueShield of Tennessee  
Provider Network Services  
1 Cameron Hill Circle, Ste 0007  
Chattanooga, TN 37402-0007

For technical support or enrollment information, call, fax, or e-mail:

- **Technical Support** call: 423-535-5717  
  E-mail: www.ecomm_support@bcbst.com

- **Enrollment** call: 1-800-924-7141  
  Fax: 423-535-7523  
  E-mail: www.ecomm_contracts@bcbst.com

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCross BlueShield of Tennessee uses the ANSI 837 version. BlueCross BlueShield of Tennessee accepts the ANSI 837 version, 5010 format. American National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

3. **Secure File Gateway (SFG)**

The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the ability to transmit files to BlueCross BlueShield of Tennessee using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="https://mftweb.bcbst.com/myfilegateway">https://mftweb.bcbst.com/myfilegateway</a></td>
<td>The BlueCross BlueShield of Tennessee secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports</td>
</tr>
<tr>
<td>SFTP (server mftsftp.bcbst.com)</td>
<td></td>
</tr>
</tbody>
</table>
The BlueCross BlueShield of Tennessee SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.

FTP/SSL (server mftssftp.bcbst.com)

The BlueCross BlueShield of Tennessee FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.

ANSI 837 (Version 5010)

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in the National Electronic Data Interchange Transaction Set Implementation Guide. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com. Additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission can be accessed at http://www.bcbst.com/providers/ebusiness/index.page.

*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in the National Electronic Data Interchange Transaction Set Implementation Guide. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com. Additional companion documents are available for BlueCross BlueShield of Tennessee electronic claims submission at: http://www.bcbst.com/providers/ecomm.

4. **Electronic Enrollment Forms**

Electronic enrollment just got easier. The Electronic Provider Profile replaces all our previous registration forms, contracts and addendums. And original signatures have been eliminated. For questions call (800) 924-7141 and speak "Enrollment".

To enroll in electronic claims filing, to add a provider to an existing electronic practice or make any changes in your electronic filing process you must complete an Electronic Provider Profile Form.

Electronic Provider Profile Form for all Providers.

If you would like to make changes to your current electronic mailbox(s), or migrate to the EC Gateway Bulletin Board System, you must complete the EC-Gateway Request for Access form.

EC-Gateway Request for Access
5. **Security Information**

In order to protect your secure access to our systems, each individual who will be accessing our systems is required to submit the [Provider Account Security Form](#).

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**H. BlueCare Plus Website**

1. **Provider Resources**

BlueCare Plus integrates self-service and electronic communication technologies as an efficient, cost-effective means to distribute BlueCare Plus provider information, education, and assistance. We take every opportunity to educate our providers about, and encourage the use of our self-service technologies. Our site is located at [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com).

The Website design offers a member/provider self-service platform while providing information and assistance regarding the Medicare and Medicaid program. The Website presents appropriate, clear and accessible information to both members and providers, with effortless access to information while adhering to all 508 accessibility, NCQA, URAC and BCBST standards, policies and procedures. Our primary goal is to provide healthcare information in an easy to use platform with self-service technology while improving user experience, in a user centric in design.
The following provider resource sections are available on bluecareplus.bcbst.com.

- **Provider Administration Manual**
  The Provider Administration Manual (PAM) offers information about our programs, and how we work with our members and providers.

- **Provider Education and Resources**
  The Provider Education and Resources section offers timely and accessible information, including additional education to review at your convenience. We offer a Provider Resource page to assist you with day-to-day operations for providing services to our members.

- **Electronic Data Interchange**
  Electronic enrollment just got easier. The Electronic Provider Profile replaces all our previous registration forms, contracts and addendums.
Clinical Practice Guidelines
BlueCare Plus follows the Clinical Practice Guidelines (CPGs) that have been adopted by BlueCross BlueShield of Tennessee. BlueCare Plus may also follow modified Practice Guidelines based on conditions relevant to our member population, TennCare, CMS and/or nationally recognized standards in which there is not a supporting corporate guideline.

Provider Resource Page

A number of reference materials are also available online giving you access to current administrative processes, and medical policies. The website contains a “find” feature making it convenient for providers to locate specific information, (e.g., billing requirements, UM guidelines, preventive care guidelines, upcoming medical policies and much more).
We invite you to visit the website often. Information and new features and timely information are added regularly.

2. **BlueAccess**

BlueAccess enables you to view the following in real time:

- Up-to-date policy
- Medical and behavioral health claim information
- Eligibility and coverage
- Prior authorizations
- View and/or print your remittance advice
- Available on [bluecareplus.bcbs.com](http://bluecareplus.bcbs.com)

Additional services are available

- PCP Membership Rosters
- Practitioner Practice Pattern Analysis – View information for your practice
- Clear Claim Connection – Code auditing interactive tool for BlueCare Plus

BlueAccess includes e-Health Services® (benefits, claims and authorization information), as well as access to Primary Care Provider member rosters, provider remittance advices and much more. First
time users must register to access these online services. Just click on the registration tab located in the BlueAccess login box on the home page of our company website, bluecareplus.bcbst.com and follow the easy registration instructions.

- **Registering for BlueAccess**
  BlueAccess is the secure online environment where a customer can review and manage information. For first time users you will need to create a login and password to access the application. To register as a provider please visit www.bcbst.com. Accessing BlueAccess allows member eligibility and coverage to be viewed on demand.

- **BlueAccess Login**
  If you are a first time user you will be required to register to use BlueAccess. In the bottom right hand corner click “register now”. You will be able to create your own unique User ID and password. After clicking the “register now” button register as “Provider”.
Registering as a Provider

BlueAccess enables providers to view information in a secure online environment, just as it appears in real time to our customer service area. Managing and monitoring your BCBST claims, reviewing your Remittance Advice and adjudicating claims are only a few of the operations you can perform with BlueAccess. This information is located in a secure area on the BCBST Web site at www.bcbst.com. BlueAccess is a quick and expedient way to streamline processes within your facility. With BlueAccess, you can see information as it currently appears in BCBST claim processing system. You may view the most current benefits information available any time you need it. Through this service, you may perform the following activities:

- Eligibility
- Benefits and Coverage details
- Claims Information
- Authorizations
- Claim Submission
- Remittance Advice

Provider numbers or National Provider Identifier (NPI) numbers are assigned a “shared secret”. The “shared secret” is the key to accessing the secure on line environment, and remains with the provider it is assigned. You may request your shared secret once you have registered with BlueAccess from the BCBST Website. After you have received your “shared secret”, return to the BCBST Website and enter the User ID and Password you created and add physicians/facilities to your profile. This information is discussed in depth in Chapter 2 of this guide.
Your facility may review the member specific information in a secure environment as follows:

- Verify eligibility
- Health care benefits
- Other insurance
- Dental coverage (if applicable)
- Status of previously submitted:
  - Claims;
  - Prior authorizations; and
  - Referrals
  - Check current and past medical and behavioral health claim status

3. **Provider Services**

In the service center, information is displayed as it currently appears in BCBST claim processing system. You get the most current benefits information available any time you need it. BlueAccess makes available to you and your staff the following information:
Keeping Data Secure with Encryption

BlueCare Plus requires a browser with 128-bit encryption strength in order to access the secure parts of its site. We are serious about protecting our members’ privacy, and this level of encryption is an industry standard for the type of information that is being exchanged.

Resources:
BlueAccess Registration Instructions

I. Member or Representative Appeals and Grievances

BlueCare Plus has incorporated formal mechanisms to address member concerns and complaints or grievances. Concerns raised by members and providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally. All other written concerns or complaints are considered grievances and will be processed through BlueCare Plus’s HMO D-SNP usual grievance procedure described in the section below. Member concerns, complaints, and resolutions, if applicable, are documented and maintained by BlueCare Plus in accordance with its corporate policies. If a member has an inquiry, concern or complaint regarding
any aspect of services received, the member may contact the designated Customer Service Representative of BlueCare Plus to discuss the matter. If a member feels that the Customer Service Representative has not resolved a problem, it is his/her right to submit a written grievance or suggestion for improvement to the Grievance Committee.

A member or representative may appeal an adverse initial decision made by BlueCare Plus concerning payment or medical necessity for a healthcare service. Appeals may include entitlement to services, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service(s).

For additional information review The Centers for Medicare & Medicaid Services (CMS) Internet Only Manuals (IOMs) Publication 100-16, Chapter 13.

1. **Definition of Terms**

   **Appeal:** An appeal includes any of the procedures that deal with the review of adverse determinations on the health care services. A member believes he or she is entitled to services, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by BlueCare Plus and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), reviews by the Medicare Appeals Council (MAC), and judicial review.

   **Assignee:** A non-contracted physician or other non-contracted provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

   **Complaint:** Any expression of dissatisfaction to BlueCare Plus, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, quality of care and the claims regarding the right of the member to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

   **Cost Sharing Obligations:** Medicare deductibles, premiums, co-payments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus’s, and Other Medicare/Medicaid Dual Eligibles). For SLMB-Plus’s and Other Medicare/Medicaid Dual Eligibles, TennCare is not required to pay Medicare coinsurance on those Medicare services that are not covered by TennCare unless the enrollee is a child under 21 or an SSI beneficiary. No Plan can impose cost sharing obligations on its members which would be greater than those that would be imposed on the member if they were not a member of the Plan.
Dual Eligible: As used in Tennessee, a Medicare enrollee who is also eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and Other Full Benefit Dual Eligible (“FBDE”).

Dual Eligible Member: An enrollee who is Dual-Eligible and is enrolled in a Plan.

Effectuation: Compliance with a reversal of the BlueCare Plus original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Encounter: A Medicare Part C covered service or group of covered services, as defined by the MA-SNP Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.

Encounter Data: In the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

Full Benefit Dual Eligible (FBDE): An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits [services], including those who are categorically eligible and those who qualify as medically needy under the State Plan.

Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in BlueCare Plus or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may make the complaint or dispute, either orally or in writing, to a BlueCare Plus, provider, or facility. An expedited grievance may also include a complaint that BlueCare Plus refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration period.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity (IRE): An independent entity contracted by CMS to review BlueCare Plus and other D-SNPs adverse reconsiderations of organization determinations.

Individually Identifiable Health Information: Information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
Inquiry: Any oral or written request to BlueCare Plus, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a member. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.

MA Agreement: The Medicare Advantage Agreement between the BlueCare and CMS to provide Medicare Part C and other health plan services to the BlueCare members.

Marketing: Shall have the meaning established under 45 CFR § 164.501 and includes the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

Medicare Advantage Plan: A plan as defined at 42 CFR. 422.2 and described at 422.4.

Medicare Health Plan: For purposes of this chapter, a collective reference to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs).

Organization Determination: Any determination made by BlueCare Plus with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;
- Payment for any other health services furnished by a provider other than the BlueCare Plus that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by BlueCare Plus;
- The Medicare health plan’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;
- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;
- Failure of BlueCare Plus to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Personally Identifiable Information (PHI): Any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's
identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.


- Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

**Qualified Medicare Beneficiary (QMB):** An individual who is entitled to Medicare Part A, who has income that does not exceed one hundred percent (100%) of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare Premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). Collectively, these benefits [services] are called “QMB Medicaid Benefits [Services].” Categories of QMBs covered by this Contract are as follows:

- **QMB Only** – QMBs who are not otherwise eligible for full Medicaid.

- **QMB Plus** – QMBs who also meet the criteria for full Medicaid coverage and are entitled to all benefits [services] under the State Plan for fully eligible Medicaid recipients.

**Quality Improvement Organization (QIO):** Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

**Quality of Care Issue:** A quality of care complaint may be filed through the BlueCare Plus HMO D-SNP grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided for BlueCare Plus meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

**Reconsideration:** A member’s first step in the appeal process after an adverse organization determination; BlueCare Plus or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

**Representative:** An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member.
or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

**Specified Low-Income Medicare Beneficiary (SLMB) PLUS:** An individual entitled to Medicare Part A who has income that exceeds 100% FPL but less than 120% FPL, and whose resources do not exceed twice the SSI limit, and who also meets the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

**Special Needs Plan (SNP) or Plan:** A type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of the TennCare Program the special class of members are persons who are both Medicare and Medicaid Dual eligible. These plans must be approved by CMS. A SNP plan may also provide Medicare Part D drug coverage.

**SSA-supplied Data:** Information, such as an individual’s social security number, supplied by the Social Security Administration to the State to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Agreement, “CMPPA” between SSA and F&A; Individual Entity Agreement, “IEA” between SSA and the State).

**State Plan:** The program administered by TennCare pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

**TennCare:** The medical assistance program administered by Tennessee Department of Finance and Administration, Division of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan, and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

**TennCare MCO:** A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits.

**A. Appeals**

- BlueCare Plus members or their representatives;
  - Have the right to request an expedited reconsideration
  - The right to request and receive appeal data from BlueCare Plus
  - The right to receive notice when an appeal is forwarded to an Independent Review Entity (IRE)
  - The right to automatic reconsideration by an IRE contracted by CMS, when BlueCare Plus upholds it original adverse determination in whole or in part.
  - The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement;
  - The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part;
The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review if unfavorable to the member, in whole or in part, and the amount in controversy meets the appropriate threshold requirement;

- The right to request a QIO review of a termination of coverage of inpatient hospital care. If the member receives immediate QIO review of a determination on non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by BlueCare Plus. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Member may submit request for QIO review of determination of non-coverage of inpatient hospital care;

- The right to request a QIO review of a termination of services in skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORF). If the member receives a QIO review of the above service termination, the member is not entitled to the additional review of the issue by BlueCare Plus.

- The right to request and be given timely access to the member’s case file and a copy of that case subject to federal and state law regarding confidentiality of patient information.

B. The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals (“aggrieved parties”) may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The appeal process is available to both members with original Medicare and those enrolled in BlueCare Plus

Below is a quick reference guide for the processes;

2. **Appeal Levels**

**Level 1 Appeal**

**BlueCare Plus**

Dissatisfied with determination by BlueCare Plus

- Member or representative may request an appeal
- Send request for reconsideration to:
  BlueCare Plus Member Appeals
  1 Cameron Hill Circle Suite 0042
  Chattanooga, TN 37402-0042
  Fax: 1.888.416.3026

- Request for reconsideration must be within 60 days of initial decision
• Member or representative will be notified:
  o 30 days if the decision involves a request for service
  o 60 days if the decision involves a request for payment

• Expedited Review in Special Circumstances
  A member or physician may request an *expedited reconsideration* by BlueCare Plus in situations where the standard reconsideration time frame might jeopardize the member’s health, life, or ability to regain maximum function. Expedited appeal request may be submitted verbally.

• If a member disagrees with BlueCare Plus decision to discharge or discontinue services while the member is receiving inpatient hospital care, skilled nursing facility care, home health care or comprehensive rehabilitation facility care, the member may request an immediate review by a Quality Improvement Organization.

• Automatic Forward to Level 2 Appeal.
  o The member’s appeal to and independent outside entity for a Level 2 review. If BlueCare Plus does not meet the response deadline it will forward the appeal to an independent outside entity for a Level 2 review.
  o If during the Level 1 appeal BlueCare Plus does not decide in the member or representative’s favor, it is required for BlueCare Plus to forward

## Level 2 Appeal

### Independent Review Entity

Dissatisfied with Reconsideration (Level 1) file Level 2 Appeal
• Independent Review Entity (IRE) (CMS contracted reviewer) conducts the Level 2 appeal (reconsidered determination)
• Level 1 automatically forwarded to Level 2 IRE of the appeals process if:
  o BlueCare Plus does not meet the response deadline
  o Unfavorable redetermination
• After the IRE has reviewed the case it will send a notice of its decision in the mail.
  o The IRE notice will include detailed information about the right to appeal to OMHA (Level 3). You may appeal to Level 3 if:
    o Dissatisfied with IRE decision
    o Amount in controversy is $140 (2013) or more (this amount may change annually)
    o Less than 60 days have passed from reconsideration determination

## Level 3 Appeal

### Office of Medicare Hearings and Appeals (OMHA)

• If you disagree with outcome of Reconsidered Determination Level 2 appeal
  o Member or representative can request hearing before the Administrative Law Judge (ALJ)
• This must be filed within 60 days
• ALJ may decide a case on-the-record if a party waives its rights to an oral hearing or in some cases when the documentary evidence supports a finding fully favorable to the appellant.

Level 4 Appeal

Medicare Appeals Council

If the member or representative is not satisfied with the Level 3 decision/dismissal, a review by the Medicare Appeals Council (MAC) may be filed.

• The MAC is part of the Departmental Appeals Board of the Department of Health and Human Services (HHS) and is independent of OMHA and ALJs
• A member may request a Medicare Appeals Council (MAC) with the following information within 60 days:
  o Beneficiary's name;
  o Name of the health services provider;
  o Date and type of service;
  o Medicare contractor or managed care organization that issued the initial determination in a member’s case; Health Insurance Claim Number (HICN);
  o OMHA appeal number;
  o Date of the Administrative Law Judge (ALJ) decision or dismissal;
  o An appointment of representative, such as CMS Form 1696 (PDF, 66.4 KB) (if applicable);
  o Any additional evidence, clearly marked as new or duplicate; and
  o Proof that a member provided copies of the request to all other parties.
• Submit the request to:
  Department of Health and Human Services
  Departmental Appeals Board, MS 6127
  Medicare Appeals Council
  330 Independence Avenue, SW, Room G-644
  Washington DC 20201
  Fax the request to (202) 565-0227

Level 5 Appeal

Federal District Court

If the member disagrees with the Level 4 decision and the amount in controversy is $1,400 ((2013) the amount may change annually)

• The member or representative may file with the Federal District Court
  o The request must be filed within 60 days of the MAC decision.
• The notice of decision from the MAC will give the member or representative about filing a civil action
  o Last level of appeals
Organization Determination/Appeal Process
Quick Reference Guide

Standard Process
- Pre-Service: 14 day time limit
- Payment: 60 day time limit

 Expedited Process
- Pre-Service: 72 hour time limit
- Payment requests cannot be expedited

Organization Determination/Appeal Process

First Appeal Level

BlueCare Plus Reconsideration
- Pre-Service: 30 day time limit
- Payment: 60 day time limit

IRE Reconsideration
- Pre-Service: 30 day time limit
- Payment: 60 day time limit

Automatic forwarding to IRE if BlueCare PLUS upholds denial

Second Appeal Level

Office of Medicare Hearings and Appeals
ALJ Hearing
Threshold $140
No statutory time limit for process

Third Appeal Level

Medicare Appeals Council
No statutory time limit for processing

Fourth Appeal Level

Federal District Court
Threshold $1,400
60 days to file

Fifth Appeal Level
(Judicial Review)

*Note: Independent Review Entity (IRE)
3. **Representatives Filing on Behalf of Members**

Individuals who represent members may either be appointed or authorized (for purposes of this chapter [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as “representatives”) to act on behalf of the member in filing a grievance, requesting an organization determination, or in dealing with any of the levels of the appeals process. A member may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on behalf of a member. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney (POA), or a health care proxy, or a person designated under a health care consent statute. Due in part to the incapacitated or legally incompetent status of a member, a surrogate is not required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee’s authorized representative.

To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form (for purposes of this section, “representative form” means a Form CMS-1696 Appointment of Representative or other equivalent written notice). An “equivalent written notice” is one that:

- Includes the name, address, and telephone number of enrollee;
- Includes the enrollee’s HICN [or Medicare Identifier (ID) Number];
- Includes the name, address, and telephone number of the individual being appointed;
- Contains a statement that the enrollee is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- Is signed and dated by the enrollee making the appointment; and
- Is signed and dated by the individual being appointed as representative, and is accompanied by a statement that the individual accepts the appointment.

Either the signed representative form for a representative appointed by a member, or other appropriate legal papers supporting an authorized representative’s status, must be included with each request for a grievance, an organization determination, or an appeal. Regarding a representative appointed by a member, unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the member and the representative. Also, the representation is valid for the duration of a grievance, a request for organization determination, or an appeal. A photocopy of the signed representative form must be submitted with future grievances, requests for organization determinations, or appeals on behalf of the enrollee in order to continue representation. However, the photocopied form is only good for one year after the date of the enrollee’s signature. Any grievance, request for organization determination, or appeal received with a photocopied representative form that is more than one year old is invalid to appoint that person as a representative and a new representative form must be executed by a member.
Please note that the OMB-approved Form CMS-1696, Appointment of Representative (AOR) contains the necessary elements and conforms to the Privacy Act requirements, and is preferred. For purposes of the Medicare health plan disseminating the AOR form, the most current edition must be used and prior versions of Form CMS-1696 are obsolete. Please note that only sections I, II, and III of the form apply to the Medicare Advantage program. Medicare health plans may not require appointment standards beyond those included in the CMS form.

Note: The CMS-1696 form, as written, applies to all Title XVIII Medicare benefits. However, a valid appointment of representative form submitted with a request that specifically limits the appointment to Part D prescription drug benefits is not valid for requests that involve Medicare Advantage (MA) benefits. In this situation, a member must properly execute a separate representative form if he or she wishes the Part D representative to also serve as his or her MA representative (or vice versa). If a representative (who is representing a member in regards to a Part D claim) files a MA grievance or requests an organization determination or appeal without a newly executed representative form, the Medicare health plan should explain to the representative that a new representative form must be executed, and provide the representative with a reasonable opportunity to submit the new form before dismissing the request.

4. Authority of a Representative

Unless otherwise stated in the 42CFR subpart M of part 422, the representative has all the rights and responsibilities of a member in filing a grievance, obtaining an organization determination, or in dealing with any of the levels of the appeals process. On behalf of the member the representative can:

- Obtain information about the member’s claim to the extent consistent with Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request or give or receive any notice about the proceedings.

All notices intended for the member must be sent to the member’s representative instead of the member.

Details for the Form: CMS 1696 can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Items/CMS012207.html.
Appointment of Representative

Name of Party

Medicare or National Provider Identifier Number

Section 1: Appointment of Representative
To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint the individual, ___________________________ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request, to present or to elicit evidence, to obtain appeals information, and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation

Date

Street Address

Phone Number (with Area Code)

City

State

Zip Code

Section 2: Acceptance of Appointment
To be completed by the representative:
I, ___________________________, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a/an ___________________________

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative

Date

Street Address

Phone Number (with Area Code)

City

State

Zip Code

Section 3: Waiver of Fee for Representation
Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and must complete this section.)

I waive my right to charge and collect a fee for representing ___________________________ before the Secretary of the Department of Health and Human Services.

Signature

Date

Section 4: Waiver of Payment for Items or Services at Issue
Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature

Date

Form CMS-1696 (Rev.06/15)
5. Complaints
Complaints may include both grievances and appeals. They may be processed as an appeal or as a grievance or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations.

6. Organization Determination
Providers or members may obtain a written advance coverage determination (known as an organization determination) from BlueCare Plus before a service is furnished to confirm whether the service will be covered. To obtain an advance organization determination, call us at 1-866-789-6314 (be sure to have the member’s ID number including the 3 character alpha prefix when you call) or fill out the form located at [http://bluecareplus.bcbst.com/docs/providers/UM_Advance_Determination_Request_Fax.pdf](http://bluecareplus.bcbst.com/docs/providers/UM_Advance_Determination_Request_Fax.pdf) and fax it to 1-866-325-6698. BlueCare Plus will make a decision and notify you and the member within 14 days of receiving the request, with a possible (up to) 14-day extension either due to the member’s request or BlueCare Plus justification that the delay is in the member’s best interest. In cases where you believe that waiting for a decision under this time frame could place the member’s life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. A physician may request an expedited determination, by calling us at 1-866-789-6314. We will notify you of our decision as expeditiously as the member’s health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-day extension either due to the member’s request or BlueCare Plus justification (for example, the receipt of additional medical evidence may change BlueCare Plus decision to deny) that the delay is in the member’s best interest. In the absence of an advance organization determination, BlueCare Plus can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan (e.g., was not medically necessary). Contracted providers have the ability to appeal and follow the outlined dispute resolution processes. Non-contracted providers have the right to dispute our decision by submitting a waiver of liability (promising to hold the member harmless regardless of the outcome), and exercising member appeals rights see the Federal regulations at 42 CFR Part 422, subpart M, Chapter 13 of the Medicare Managed Care Manual).

7. Notice Requirements for Non-contract Providers
If BlueCare Plus denies a request for payment from a non-contract provider, BlueCare Plus will notify the provider of the specific reason for the denial and provide a description of the appeals process. A written notification will be provided.

Non-contract Provider Appeals
A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal.
8. Re-openings and Revising Determinations and Decisions

A reopening is a remedial action to change a final determination or decision even though the determination or decision was correct based on the evidence of record. The action may be taken by the following:

BlueCare Plus to revise the organization determination or reconsideration
An IRE to revise the reconsidered determination.

- An ALJ to revise the hearing decision
- The MAC to revise the hearing or review decision

BlueCare Plus processes clerical including minor errors and omissions as reopening rather than reconsiderations. If however a request for reopening is submitted and after review determined that the issue is a clerical error, the reopening request will be dismissed and the member or representative will be advised of any appeal rights, provided the timeframe to request an appeal on the original claim has not expired.

Examples of errors may include mathematical or computational mistakes, inaccurate data entry or denials of claims as duplicates.

According to CMS regulations, BlueCare Plus must process clerical errors, minor errors and omissions as a reopening.

The following are guidelines for submitting a reopening request:

- The request must be made in writing;
- The request for a reopening must be clearly stated;
- The request must include the reason for requesting a reopening; and
- The request should be made within the time frames permitted;

9. Re-opening Timeframes

- Within 1 year from the date of the organization determination or reconsideration for any reason;
- Within 2 years plus the current year from the date of the organization determination or reconsideration for good cause;
- At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the organization determination was procured by fraud or similar fault;
- At any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based; or
- At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.
Resource


10. Provider Dispute Resolution

Purpose: To address and resolve any and all matters causing participating Providers (“Providers”) or BlueCross BlueShield of Tennessee or its affiliated companies (“BCBST”) to be dissatisfied with any aspect of their relationship with the other party (a “Dispute”). Providers are encouraged to contact a representative of BlueCross BlueShield of Tennessee’s Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

*Non-contracted, non-participating, and out-of-state Providers may also utilize the PDRP pursuant to the terms hereof and in accordance with BCBST policy.

Introduction.

A. This Procedure describes the exclusive method of resolving any Disputes related to a Provider’s participation in BCBST’s network(s). It is incorporated by reference into the participation agreement between the parties (the “Participation Agreement”) and shall survive the termination of that Agreement.

B. This Procedure shall only be applicable to resolve Disputes that are subject to BCBST’s or the Provider’s control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party’s control (e.g. determinations made by a customer purchasing administrative services only (“ASO Customers”) from BCBST).

C. This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant’s professional qualifications, conduct or competence must be resolved pursuant to BCBST’s “Medical Management Corrective Action Plan” (Section XI.D).

D. The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.

E. This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it is not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.

F. A party must commence an action to resolve a Dispute pursuant to this Dispute Resolution Procedure within eighteen (18) months of the date of the event causing that Dispute occurred (e.g. ...
the date of the letter informing the Provider of a determination) or, with respect to a Provider request for reimbursement of unpaid or underpaid claims, within eighteen (18) months of the date the Provider received payment or, in the event of unpaid claim, the date the Provider received notice that the claim was denied. This provision shall not extend the period during which a Participating Provider must submit a claim to BCBST pursuant to applicable provisions of the Provider’s agreement(s) with BCBST, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within eighteen (18) months after receiving notice of the denial of that claim. If BCBST discovers a matter creating a Dispute with a Participating Provider during an audit which is in progress at the end of the eighteen (18) month period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

G. ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES’ SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.

DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.

A. INQUIRY/RECONSIDERATION.

Providers should contact a representative of the BCBST division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g. the Claims Service Department if there is a question concerning a claims related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Network Management Division for assistance in directing their inquiries to the appropriate BCBST representative. BCBST may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g. an office manager). If a party cannot respond immediately to the other party’s inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

B. APPEAL.

If not satisfied, a party may submit a written appeal within sixty (60) days after receiving the other party’s response to its inquiry/reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

C. BINDING ARBITRATION.

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration.
within sixty (60) days after it receives a response to its appeal. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party shall be responsible for one-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BCBST.

The arbitrators: shall consider each claimant's demand individually and shall not certify or consider multiple claimants’ demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the Provider’s participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

D. EFFECTIVE DATE.

This procedure statement was adopted by BCBST on June 1, 1997.

Note: The former Provider Dispute Form has been replaced with the following fillable forms located on BlueCare Plus Tennessee website: Provider Reconsideration Form

Provider Reconsideration Form and the Provider Appeal Form are located at www.bcbst.com/providers/forms/reconsideration-and-appeals.page.
III. Enrollment and Requirements

A. Overview

BlueCare Plus is an HMO Special Needs Plan (SNP) that limits membership to people that are Medicare and Medicaid eligible with specific diseases or characteristics and tailors the members’ benefits, provider choices and drug formularies (list of covered drugs) to best meet the specific needs of members, in this complex population.

BlueCare Plus is approved by Medicare and is available for individuals that have Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and Medicaid. When an individual joins BlueCare Plus, the benefits include physical and behavioral health services and prescription drug coverage. As a result, of coordinating all health care services through a single plan BlueCare Plus can help individuals manage all services and providers. A non-qualifying individual that disenrolls from BlueCare Plus may re-enroll if the individual once again meets the specific qualifying characteristic(s) of BlueCare Plus. If an individual joins BlueCare Plus the following is applicable;

- Member is still in the Medicare program
- Member still has Medicare rights and protections
- Receives Medicare Part A and Part B coverage through BlueCare Plus
- Receives Medicare prescription drug coverage
- Additional benefits tailored to the groups we serve
- Coordination with the member; Medicaid MCO regarding medical services

Members can enroll in BlueCare Plus through;
- Online Enrollment Center [http://bluecare.bcbst.com](http://bluecare.bcbst.com)
- Calling BlueCare Plus
  - Member Service 800-332-5762
  - Provider Service 800-299-1407

The Centers for Medicare & Medicaid (CMS) offer periods when Medicare beneficiaries can enroll or disenroll from Medicare plans. These times are known as election periods. BlueCare Plus is a Special Needs Plan and all of our members qualify for the Special Election Period (SEP) every month.

B. Disenrollment

A member can remain enrolled in the BlueCare Plus if the member continues to meet the chronic SNP served by BlueCare Plus. As a D-SNP program, all our members qualify for the Special Election Period (SEP) every month. The Special Election Period constitutes periods outside of the usual enrollment period. The SEP permits our member to enroll or disenroll at any time throughout the
year. For more information regarding the Special Election Period visit bluecareplus.bcbst.com or www.cms.gov. A member may be disenrolled if the member loses Medicaid eligibility.

A BlueCare Plus member may request a disenrollment during one of the election periods. A member may disenroll by:

- Enrolling in another plan (during a valid enrollment period)
- Giving or faxing a signed written notice to BlueCare Plus
- Calling 1-800-MEDICARE or visiting www.medicare.gov

If a representative is assisting the member with disenrollment the following must occur:

- Attest that he or she has the authority under State law to make the disenrollment request on behalf of the member
- Attest that proof of this authorization, as required by State law that empowers the representative to effect a disenrollment on behalf of the member
- Provide contact information

C. Summary of Benefits

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<th>Physician Services</th>
<th>Hospital and Ancillary Services</th>
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<tr>
<td>Tennessee</td>
<td>Bill TennCare for cost sharing</td>
<td>Bill TennCare for cost sharing</td>
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TennCare is obligated to pay for Medicare deductibles and coinsurance for Medicare beneficiaries classified as QMBs and SLMB Plus and other dual eligible recipients. TennCare is not required to pay Medicare coinsurance for non-covered services for SLMB Plus and other dual eligible recipients unless the enrollee is a child under age 21 or an SSI beneficiary. Cost-sharing obligations do not include:

- Medicare premiums that TennCare is required to pay under the State Plan on behalf of dual eligible members
- Payments for any Medicaid services that are covered solely by TennCare
- Any cost sharing for a Part D prescription drug

BlueCare network providers are required to refer dual-eligible members who are QMB Plus or other FBDE recipients to the members’ TennCare managed care organization for the provision of TennCare benefits that are not covered by the BlueCare Plus plan.

TennCare offers a broad array of long-term services and supports designed to help meet Members unique needs. Long-Term Services & Supports (LTSS) is a variety of services which help meet both the medical and non-medical need of people with a chronic illness, physical disability and intellectual disability who cannot care for themselves for long periods of time. It is common for long term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and using the bathroom. Increasingly, long-term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions.
associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. Long-term services or supports may be needed by people of any age, even though it is a common need for senior citizens.

The Tennessee’s CHOICES program provides the elderly (65 years of age and older) & adults with physical disabilities (21 years of age and older) who are eligible for TennCare with needed long term services and supports in the home/community setting or nursing home. Information about the TennCare Managed Care Organization and available TennCare Program Benefits can be found at the following TennCare Program web sites:

[https://www.tn.gov/tenncare/providers.html](https://www.tn.gov/tenncare/providers.html)
[https://www.tn.gov/tenncare/members-applicants.html](https://www.tn.gov/tenncare/members-applicants.html)
[https://www.tn.gov/tenncare/long-term-services-supports.html](https://www.tn.gov/tenncare/long-term-services-supports.html)

Providers should refer to the Division of TennCare Medicare and Medicaid Crossover Claims directions outlined on the TennCare Bureau web site at:
[https://www.tn.gov/tenncare/providers/medicare-medicaid-crossover-claims.html](https://www.tn.gov/tenncare/providers/medicare-medicaid-crossover-claims.html)

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<th>BlueCare Plus</th>
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<td><strong>Description</strong></td>
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<td><strong>Premium</strong></td>
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<td>OOP Maximum (The OOP Max is only accumulated when the member actually pays cost sharing)</td>
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<td>Inpatient Hospital Care</td>
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<td>Inpatient Mental Health Care</td>
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<td>Diagnostic Tests, X-Rays, Lab,</td>
</tr>
<tr>
<td>and Therapeutic radiology</td>
</tr>
<tr>
<td>lab</td>
</tr>
<tr>
<td>diagnostic tests</td>
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<tr>
<td>x-rays</td>
</tr>
<tr>
<td>advanced imaging</td>
</tr>
<tr>
<td>Service Description</td>
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<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>therapeutic radiology</td>
</tr>
<tr>
<td>Cardiac/Pulmonary Rehab</td>
</tr>
<tr>
<td>Preventive Services and Wellness/Education Programs</td>
</tr>
<tr>
<td>Abdominal Aortic Aneurysm Screening</td>
</tr>
<tr>
<td>Bone Mass Measurement</td>
</tr>
<tr>
<td>Colorectal Screening Exams</td>
</tr>
<tr>
<td>Immunizations/vaccines</td>
</tr>
<tr>
<td>Mammograms (Annual)</td>
</tr>
<tr>
<td>Pap Smears and Pelvic Exams</td>
</tr>
<tr>
<td>Prostate Cancer Screening Exams</td>
</tr>
<tr>
<td>Physical Exams</td>
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<tr>
<td>ESRD/Dialysis</td>
</tr>
<tr>
<td>Prescription Drugs</td>
</tr>
<tr>
<td>Gap coverage</td>
</tr>
<tr>
<td>Formulary</td>
</tr>
<tr>
<td>B-covered drugs (not including chemotherapy drugs)</td>
</tr>
<tr>
<td>Part B-covered chemotherapy drugs</td>
</tr>
<tr>
<td>Dental Services</td>
</tr>
<tr>
<td>Routine Services</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>$0 for - up to 2 oral exam(s) every yr - up to 2 cleaning(s) every yr - up to 1 dental x-ray every yr</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare covered</th>
<th>Medicare Standard Part B Cost Sharing</th>
<th>Zero Cost Sharing</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>Hearing Services -</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Medicare covered only</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>routine</td>
<td>$1,000 plan coverage limit for supplemental routine hearing exams and hearing aids every year.</td>
<td>$1,000 plan coverage limit for supplemental routine hearing exams and hearing aids every year.</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Vision Services</th>
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<tbody>
<tr>
<td>Medicare covered only</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>glasses/contacts (eyewear)</td>
<td>$200 allowance / every yr</td>
<td>$200 allowance / every yr</td>
</tr>
<tr>
<td>routine exam</td>
<td>$0 copay for one exam each yr</td>
<td>$0 copay for one exam each yr</td>
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<table>
<thead>
<tr>
<th>Wellness/Education and Other Supplemental Benefits &amp; Services</th>
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<tbody>
<tr>
<td>Health Club Membership/Fitness Classes</td>
<td>Silver Sneakers</td>
<td>Silver Sneakers</td>
</tr>
<tr>
<td>24 Hour Nursing Hotline</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Over-the-Counter Items</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
OTC Catalog: $150 allowance / every qtr

Transportation

<table>
<thead>
<tr>
<th></th>
<th>Original Medicare</th>
<th>BlueCare Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA.</td>
<td>Not available</td>
<td>Up to 50% off a wide range of health-related products and services through BluePerks*</td>
</tr>
<tr>
<td>BB.</td>
<td>Not available</td>
<td>Nation’s leading exercise program with Silver Sneakers**</td>
</tr>
<tr>
<td>CC.</td>
<td>Not available</td>
<td>Nurseline***</td>
</tr>
</tbody>
</table>

**BluePerks** - Created exclusively for BlueCross BlueShield of Tennessee members, BluePerks features discounts of up to 50 percent on a wide variety of alternative medical procedures – such as massage therapy, acupuncture and more. Plus, BluePerks also includes savings on health and wellness services, such as fitness centers, spas, personal trainers, Tai Chi classes and vitamins.

**Silver Sneakers** - A basic fitness center membership at a participating location near you with access to the basic amenities; Custom designed, low impact classes designed to improve your body’s strength and flexibility; On-site advisors to act as your contact for information and personalized service; and Social events.

***Nurseline** - This is a valuable resource for you should your BlueCare Plus patients have non-emergency health service questions or concerns after your office hours. The number to call is 1-888-747-8951. Should a member have a serious health concern, such as chest pain, they should call 911.
D. Member ID Cards

BlueCare Plus ID Card

BlueCare Plus members should receive an Identification card (ID) prior to the effective date. However, if a member does not receive the ID card you can access member eligibility information on the BlueCare Plus Website at bluecareplus.bcbst.com or contacting the BlueCare Plus customer service line at 1-800-332-5762.

Presentation of the ID card does not guarantee eligibility. The card is for identification purposes only. Eligibility should be verified at the time services are received. The process of verifying eligibility is essential to avoid the following circumstances:

- Member may no longer be eligible
• Benefits may be altered
• Fraudulent use may occur

E. Primary Care Provider (PCP)

PCPs are responsible for the overall health care of BlueCare Plus members assigned to them. Responsibilities associated with the role include, but are not limited to:

• Coordinating the provision of initial and primary care;
• Providing or making arrangements for all medically necessary and covered services;
• Initiating and/or authorizing referrals for specialty care;
• Collaboration with the care coordinator and the Interdisciplinary Care Team (ICT);
• Monitoring the continuity of member care services;
• Routine office visits for new and established members;
• Counseling and risk intervention, family planning
• Immunizations and other preventive services
• Administering and interpreting a members health risk assessment results;
• Medically Necessary X-ray and laboratory services;
• In-office test/procedures as part of the office visit;
• Maintaining all credentials necessary to provide covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
• Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy in this Manual).

BlueCare Plus PCPs have agreed to fulfill special roles and responsibilities associated with the management and care of BlueCare Plus members. In return for the additional efforts in caring for BlueCare Plus members, PCPs receive a higher reimbursement rate for participation in the Model of Care (MOC) Training and Interdisciplinary Care Team (ICT).

The Membership Listings are available electronically via BlueAccess. BlueCare Plus secure area of its company website bluecareplus.bcbst.com and www.bcbst.com. If you have not registered for BlueAccess visit us online at bluecareplus.bcbst.com click register under BlueAccess. In the BlueAccess login box and follow registration instructions. If you need assistance, contact our eBusiness Service Center at 423-535-5717 or email Ecomm_TechSupport@bcbst.com.

There are four report selections available:

• Added Members Since Last Report
  o Lists information about newly assigned members reflected on the current listing. These members should not be listed on any previous membership listings for the provider.
• Current Members
  o Lists information about members assigned to the provider on the previous membership listing
• Members Transferred from Provider
  o Lists information about members transferred to another PCP or MCO
• Dropped Members
  o Lists information about members who have either changed MCOs or are no longer eligible for TennCare

The legend below describes fields on the PCP Membership Listing:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Date the member listing report was created</td>
</tr>
<tr>
<td>Pay To</td>
<td>Address where the PCP’s payment was sent</td>
</tr>
<tr>
<td>Member Name</td>
<td>Member last name, first name and middle initial</td>
</tr>
<tr>
<td>Effective with PCP</td>
<td>Date member assigned to PCP. The names are listed alphabetically, last name first.</td>
</tr>
<tr>
<td>Member Address</td>
<td>Address of assigned member</td>
</tr>
<tr>
<td>DOB/Sex/SSN</td>
<td>Date of birth, gender of assigned member and his/her Social Security Number</td>
</tr>
<tr>
<td>ID Number/Old Member</td>
<td>New identification number, old Social Security Number</td>
</tr>
<tr>
<td>Effective Date of Coverage</td>
<td>Date the member became eligible for BlueCare Plus</td>
</tr>
<tr>
<td>Future Disenroll Date</td>
<td>Date member will be disenrolled from the BlueCare Plus program. This date will change if the Division of TennCare notifies us of eligibility status change</td>
</tr>
<tr>
<td>Effective with PCP</td>
<td>Date member became effective with PCP</td>
</tr>
</tbody>
</table>

The Primary Care Provider change considered initiated when:

• A member calls in a PCP change request to BlueCare Plus Customer Service line;
• A member mails in a written PCP change request to BlueCare Plus Customer Service
• A member mails a postage-paid PCP Change Card to BlueCare Plus (cards are available in the Member’s BlueCare Plus Directory and BlueCare Plus Member Handbook or
• PCP Change Form faxed to BlueCare Plus are only accepted if the member is:
  o New to BlueCare Plus or in need of help submitting the change.
  o Reflect reason for change in the form.
• PCP change requests are made effective on the date of the request. Miscellaneous PCP Assignment Information
• When a member requests a new PCP, the member must fall within the PCP’s stated patient accept criteria
• If a PCP wants to change his/her patient accept criteria, he/she must submit a written request to the Provider Management Department. This request can be submitted on a Primary Care Provider Change Form or on the PCP’s letterhead and mail to
Primary Care Provider Change Request Form

Please complete and fax to: 1-888-261-9025

Member Information:

Member ID __________________________ Date of birth (month/day/year) __________________________

Member Name: First __________________________ MI __________________________ Last __________________________

Address __________________________ __________________________ __________________________

City __________________________ State __________________________ ZIP __________________________

Phone Number __________________________ Signature __________________________

Provider Information:

Name of New PCP __________________________ Provider Number __________________________

Address __________________________ __________________________ __________________________

City __________________________ State __________________________ ZIP __________________________

Phone Number __________________________ Fax Number __________________________ Email Address __________________________

Physician Signature __________________________ Date __________________________ NPI Number __________________________

Reason for the change:
☐ Established Patients Only
☐ Override age restrictions
☐ Override patient load
☐ Other (please explain) __________________________

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association.

BlueCare Plus Tennessee is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid program. Enrollment in BlueCare Plus Tennessee depends on contract renewal.

Y0013_14_DPCFRM (V/14)
IV. General Guidelines for Benefits

A. Overview

The scope of the benefits under Medicare Part A and Medicare Part B is defined in the Social Security Act. The scopes of Part A and Part B are discussed in sections 1812 and 1832 of the Act, respectively, while section 1861 of the Act lays out the definition of medical and other health services. Specific health care services must fit into one of these benefit categories, and not be otherwise excluded from coverage under the Medicare program (see §1862 for exclusions). In general, the Act lists categories of items and services covered by Medicare, although Congress occasionally adds specific services to be covered by Medicare. Some categories are defined more broadly than others; for example, the Act includes hospital outpatient services furnished incident to physicians’ services (§1861(s)(2)(B)) but also specifically includes diabetes screening tests (§1861(s)(2)(Y). The Act vests in the Secretary the authority to make determinations about which specific items and services, within categories, may be covered under the Medicare program. Further interpretation is provided in the Code of Federal Regulations and CMS guidance.

BlueCare Plus coverage and payment is contingent upon the following:
1. A service must be a covered benefit in a member’s Evidence of Coverage;
2. A service must not be excluded; and
3. A service must be appropriate and medically necessary.

BlueCare Plus uses the following hierarchy of references to determine coverage:
- The law (Title 18 of the Social Security Act);
- The regulations (Title 42 Code of Federal Regulations (CFR) Parts 422 and 476);
- National Coverage Determinations (NCDs) Manual Publication 100-03 of Medicare’s Internet Only Manuals;
- Benefit Policy Manual Publication 100-02 of Medicare’s Internet Only Manuals;
- Local Coverage Determinations (LCDs);
- Coverage guidelines in Interpretative Manuals (Medicare’s Internet Only Manuals, sub-manuals) including:
  - Claims Processing Manual Publication 100-04;
  - Program Integrity Manual Publication 100-08;
  - Quality Improvement Organization Manual Publication 100-10;
  - Medicare Managed Care Manual Publication (100-16)
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC);
- Associated Program Safeguard Contractor (PSC) Local Coverage Determinations;
- MCG criteria;
- BlueCross Utilization Guidelines;
- U.S. Food and Drug Administration approved indications for medications;
- Supplemental benefits and limitations as outlined in a member’s Evidence of Coverage;
- BCBST Policy; and
• Other major payor policy and peer reviewed literature.

Part B drugs: No dollar limits may be placed on the provision of Part B drugs covered under Original Medicare unless the Medicare statute imposes the limit on Original Medicare coverage, it is specified in a national or applicable local coverage determination, or CMS imposes a dollar limit (Reference Medicare Managed Care Manual Publication 100-6 Chapter 4).

BlueCare Plus is an HMO D-SNP for beneficiaries enrolled in Medicare and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the Medicare Saving programs categories that are offered to help members with Medicare pay Medicare cost sharing:

**Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing like deductibles, coinsurance, and copayments. Some people with QMB are also eligible for full TennCare (Medicaid) benefits (QMB+).

**Specified Low-Income Medicare Beneficiary Plus (SLMB+):** Helps pay Part B premiums and are also eligible for full TennCare (Medicaid) benefits.

BlueCare Plus confirms eligibility, including both Medicare eligibility and Medicaid eligibility prior to enrollment.

A BlueCare Plus member’s eligibility for enrollment is based on his/her eligibility for Medicaid. Medicaid eligibility is subject to changes due to variation in the enrollee’s income from one month to another or to changes in the State’s criteria for eligibility. Thus, a dual eligible enrollee of BlueCare Plus may become ineligible for the plan due to the loss of his/her Medicaid eligibility for a period of time that may be one, or many months in duration. When a BlueCare Plus member loses Medicaid eligibility, BlueCare Plus will provide assistance to re-establish a member’s Medicaid status. However, the expected period of loss of eligibility cannot exceed six months.

### B. Emergent and Urgently Needed Care

BlueCare Plus uses CMS’ definition of emergent and urgently-needed services as described in the Medicare Managed Care Manual Publication 100-16 Chapter 4. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.
Emergency medical condition status is not affected if a later medical review found no actual emergency present.

**Emergency services** are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

**Urgently-needed services** are covered services that:

- Are not emergency services as defined above but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when a member is temporarily absent from the BlueCare Plus service area and unable to obtain needed services from a network provider or when a member is in the service area, but the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services from his/her regular network provider after the member returns to the service area or a network provider becomes available.

BlueCare Plus does not require prior approval of emergency or urgently-needed covered services.

**Stabilization of an Emergency Medical Condition**

A physician treating a member is responsible for deciding when the member may be considered stabilized for transfer or discharge.

**Post Stabilization Care Services**

Post stabilization care services are covered services that are:

- Related to an emergency medical condition;
- Provided after a member is stabilized; and
- Provided to maintain the stabilized condition, to improve or resolve the member’s condition.

**Member Protections Related to Plan-Directed Care**

In accordance with Medicare Managed Care Manual Chapter 4, CMS considers a contracted provider an agent of BlueCare Plus. As an agent for us, it is the responsibility of contracted providers to know whether specific items and services are covered in our BlueCare Plus plan. Additionally, contracted providers are expected to coordinate care/services with other contracted providers and ensure the member is receiving medically necessary services. Providers should contact BlueCare Plus’ UM Department at 1-866-789-6314 or fax clinical information supporting the need for services to be provided by a non-contracted provider to 1-866-325-6698 prior to rendering the service. This does not apply to emergency or urgently-needed services as described above.
C. Services, Supplies and Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be DME. Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member.

Medical supplies of an expendable nature, such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered “durable” within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

For purposes of rental and purchase of DME a member’s home may be his/her own dwelling, an apartment, a relative’s home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)). However, an institution may not be considered a member’s home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

1. Medical Equipment

Equipment presumptively constituted as medical equipment includes:

- Hospital beds
- Wheelchairs
- Hemodialysis equipment (also covered as a prosthetic device)
- Iron lungs
- Respirators
- Intermittent positive pressure breathing machines
- Medical regulators
- Oxygen tents
- Crutches
- Canes
- Trapeze bars
Special Exception Items
Specified items of equipment may be covered under certain conditions even though they do not meet the definition of DME because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:
- gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who had bed sores or there is medical evidence indicating highly susceptible to ulceration; and
- heat lamps for medical therapy where the need for heat therapy has been established.

Repair, Maintenance, and Replacement of Medically Required DME Repairs
Repairs to equipment a member owns are covered when necessary to make the equipment serviceable after damage or wear. See Non-Covered Benefits section below related to repair, maintenance or replacement of equipment in frequent and substantial servicing or oxygen equipment.

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

Maintenance
Extensive maintenance which, based on the manufacturers' recommendations and performed by authorized technicians, is covered as repairs for medically necessary equipment which a member owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

A new CMN and/or physician's order is not needed for covered maintenance.

Replacement
Equipment a member owns or is a capped rental item may be replaced in cases of loss or irreparable damage to a specific accident or a natural disaster such as fire or flood.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item.

Coverage of Supplies and Accessories
Supplies that are necessary for the effective use of DME are covered. Such supplies include drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system. However, the coverage of such drugs or biologicals does not preclude the need for a determination that the drug or biological itself is reasonable and necessary for treatment of the illness or injury or to improve the functioning of a malformed body member.
Preferred DME product or brand is available on the BlueCare Plus Website in members’ Evidence of Coverage document.

2. **Prosthetics**

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician’s order. Examples include:

- Artificial limbs
- Parenteral and enteral nutrition and accessories and/or supplies
- Cardiac pacemakers
- Prosthetic lenses
- Breast prostheses including surgical brassiere post mastectomy
- Maxillofacial devices
- Devices replacing all or part of the ear or nose
- Urinary collection and retention system with or without a tube to replace bladder function in case of permanent incontinence
- Foley catheter for permanent urinary incontinence
- Colostomy and other ostomy bags, necessary accessories required for attachment, irrigation/flushing equipment, and other items/supplies directly related to ostomy care, whether the attachment of a bag is required
- Back braces

**Prosthetics Replacement**

Replacement of a prosthetic device that is an artificial limb, or replacement part of a device is covered if the ordering physician determines that the replacement device or part is necessary because of any of the following:

- a change in the physiological condition of the patient;
- an irreparable change in the condition of the device, or in a part of the device; or
- the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

**Prosthetic Supplies, Repairs, Adjustments, and Replacement**

Supplies are covered that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient’s condition is covered when ordered by a physician. General provisions relating to the repair and replacement of DME as described above for the repair and replacement of prosthetic devices are applicable.

Adjustments to an artificial limb or other appliance required by wear or by a change in the patient’s condition are covered when ordered by a physician.

**D. Chiropractic Services**
Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands, of the spine. Additionally, manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

No other diagnostic or therapeutic service furnished by a chiropractor or under the chiropractor’s order is covered. This means that if a chiropractor orders, takes, or interprets an x-ray, or any other diagnostic test, the x-ray or other diagnostic test, can be used for claims processing purposes, but BlueCare Plus coverage and payment are not available for those services.

E. Part B Drugs

BlueCare Plus provides our members with coverage of all drugs covered under original Medicare Part B. BlueCare Plus covers Part B drugs that are furnished “incident to” a physician’s service provided that the drugs are not usually self-administered by patients who take them. Part B drugs include:

- Immunosuppressive drugs for individuals who had an organ transplant that was covered by BlueCare Plus at a Medicare approved facility;
- Parental or intradialytic parenteral nutrition for members with non-functioning digestive tract
- Intravenous immune globulin (IVIG) provided in the home for individuals with diagnosis of primary immune deficiency disease
- Certain oral chemotherapy agents used in cancer treatment for which there is an infusible version of the drug
- Oral anti-emetics used in cancer treatment as a full replacement for intravenous treatment
- Hepatitis B vaccine for individuals at high or intermediate risk
- Inhalation DME supply drugs
- Drugs furnished “incident to” a physician service
- Drugs that are separately billable from Part D
  - ESRD
  - Drugs administered hospital outpatient department
  - Drugs administered in Comprehensive Outpatient Rehabilitation Facilities
- Drugs packaged under the Outpatient Prospective Payment System
- Drugs furnished by ESRD facilities and included in Medicare’s ESRD composite rate
- Ostelporosis drugs provided by home health agencies under certain conditions
- Drugs furnished by:
  - Critical Access Hospital outpatient departments
  - Rural Health Clinics
  - Federally Qualified Health Centers
  - Community Mental Health Centers
  - Ambulances
Non-DME drugs covered as supplies (including radiopharmaceuticals both diagnostic and therapeutic and low osmolar contrast media
• Blood clotting factors
• Antigens
• Pneumococcal and influenza vaccines

For additional information about the Medicare-covered Part B drug list visit CGS, a Medicare Administrative Contractor.

F. Hospice

Original Medicare, rather than BlueCare Plus, pays for hospice services for a member who has elected hospice. BlueCare Plus will continue to pay for non-hospice and supplemental benefit services.

G. Out of Area Renal Dialysis Services

A member may select a qualified dialysis provider for medically necessary dialysis services if the member is temporarily absent from BlueCare Plus service area and cannot reasonably access the BlueCare Plus contracted providers. Prior authorization is not required in this situation.

H. Referral Guidelines

In BlueCare Plus, members will choose or be assigned a Primary Care Physician (PCP) for their health care needs. The PCP is responsible for the coordination of BlueCare Plus members' healthcare and routine health care needs.

BlueCare Plus does not require referrals from a PCP to a contracted specialist. If a member needs to obtain services from a non-contracted provider a prior authorization is required.

Members may receive services such as those listed below without prior approval from their PCP.

• Routine women’s health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as provided from a contracted provider.
• Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as provided from a contracted provider.
• Emergency services from contracted providers or from non-contracted providers.
• Urgently needed care from contracted providers or from non-contracted providers when contracted providers are temporarily unavailable or inaccessible, e.g., when a member may be temporarily outside of the BlueCare Plus service area.
Kidney dialysis services that a member may receive at a Medicare-certified dialysis facility when the member is temporarily outside the plan’s service area.

I. Therapy Caps and Exceptions

The statutory Medicare Part B outpatient therapy cap is an annual per beneficiary therapy cap amount determined for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. The annual update is published on The Centers for Medicare and Medicaid, Therapy Cap page. Prior authorization is for required for therapy services.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Therapists’ private practices
- Offices of physicians and certain non-physician practitioners
- Part B skilled nursing facilities
- Home health agencies (Type of Bill (TOB) 34X)
- Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities-ORFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospital outpatient departments (HOPDs)

J. Behavioral Health Services

BlueCare Plus offers a fully integrated physical and behavioral model designed to serve the needs of its members. Our system of care eliminates the separation of physical and behavioral health and social needs and prevents the fragmentation of services. The cornerstone of this model is the Care Team, which is led by the Primary Care Provider (PCP) and is unique to the member’s health care needs. The Care Team is comprised of all individuals responsible for the care of the member, including health care providers, family, state and community resources, and BlueCare Plus’s Care Facilitators. The composition of the Care Team may change over time, or remain static depending on the needs of the member. Members of the Care Team may be permanent for a member who may have chronic pathology or behavioral health needs. The expectation is that behavioral health providers will be active members of this team ensuring the member’s needs are met across time. We believe for managed care to be effective, the delivery of care must occur in an environment where the major participants are working together to achieve the same purpose. An active partnership is essential for significant health improvements to occur in the BlueCare Plus population. BlueCare Plus strongly believes that members, providers, and our organization are all intertwined by four common interests:

- achieving outcomes;
- promoting recovery, resiliency and wellness;
- managing resources; and
- managing care.
Our care management programs are designed to support effective and efficient integration of PCP and behavioral health services through a variety of joint coordination mechanisms within our Utilization Management program, Case Management programs and Population Health programs.

**Covered Services**

**Outpatient/Inpatient Behavioral Health Services**

Benefits are available for clinical assessment, diagnosis, and referral, as well as inpatient and outpatient services for treatment of behavioral health disorders (mental health, alcoholism and substance abuse). To arrange prior authorization call:

**Prior Authorization**

The following behavioral health levels of care require prior authorization:

- Inpatient
- Subacute
- Detoxification
- PHP
- ECT
- Psychological Testing
- 23-Hour Bed

Prior Authorization services for physical and behavioral health services can be arranged by calling the Utilization Management Department Monday through Friday, 8 a.m. to 6 p.m. (ET) at one of the statewide telephone numbers listed below:

**BlueCare Plus**

1-866-789-6314

**Provider Network Participation**

Please be aware not all disciplines described are eligible for participation in the BlueCare Plus networks. In addition to network participation criteria that applies for all provider networks, providers must also be enrolled in Medicare and Medicaid and complete a Disclosure of Ownership and Control Interest statement in order to receive reimbursement for treating BlueCare Plus members.

If you have questions about network eligibility, please contact your assigned regional BlueCare Plus Provider Network Manager or call 1-800-397-1630.

**Credentialing Process for Behavioral Health Providers**

All providers who participate in BlueCare Plus Provider Network must be credentialed/re-credentialed according to BlueCare Plus requirements. For a detailed listing of credentialing requirements for practitioners and facilities, visit [http://www.bcbst.com/providers/contracting-credentialing.page?](http://www.bcbst.com/providers/contracting-credentialing.page?). Among these requirements is primary source verification of the following information:
• Current, valid license to practice as an independent provider at the highest level certified or approved by the state for the provider’s specialty or facility/program status;
• License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements;
• Clinical privileges in good standing at the institution designated as the primary admitting facility, with no limitations placed on the provider's ability to independently practice in his/her specialty;
• Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure;
• Current Board certification, if indicated on the application;
• A copy of a current DEA and CDS Certificate, as applicable;
• No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider which disclose an instance of, or pattern of, behavior which may endanger members;
• No exclusion or sanctions from government programs (i.e. Medicare/Medicaid);
• Current specialized training as required for providers;
• Current and adequate malpractice insurance coverage;
• An appropriate work history for the provider's specialty (practitioner only);
• No adverse record of failure to follow BlueCare Plus policies, procedures or Quality Management activities. No adverse record of provider actions that violate the terms of the Provider Agreement;
• No adverse record of indictment, arrest or conviction of any felony or any crime indicating member endangerment;
• No criminal charges filed relating to the provider's ability to render services to members; and
• No action or inaction taken by provider that, in BlueCare Plus sole discretion, results in a threat to the health or well-being of a member or is not in the member's best interest.
• Behavioral Health Providers (facilities and programs) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by BlueCare Plus including The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Commission on Accreditation (COA), American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), Accreditation Association for Ambulatory Health Care (AAAHC) DetNorske Veritas (DNA), or Community Health Accreditation Program (CHAP) must have their accreditation status verified. In addition, non-accredited organizational providers may undergo a structured site visit to confirm they meet BlueCare Plus standards standing with state and federal authorities and programs will be verified. BlueCare Plus will not reimburse a provider if a service is a non-credentialed and/or non-contracted non-covered benefit. All practitioner locations where services are rendered or that fall under the same tax identification number will be considered a part of the BlueCare Plus Network.

• NOTE: Behavioral Health practitioner disciplines currently recognized for all Medicare programs and eligible for participation in BlueCare Plus are limited to physicians, advanced practice nurses, psychologists, and social workers.
Contact Us

Providers can locate valuable information, tools and resources on our company websites, bluecareplus.bcbst.com and www.bcbst.com. The websites offer access to comprehensive information and practical recommendations related to addiction and recovery, mental and behavioral health, medications, life events, and daily living skills. Providers having questions or needing to arrange behavioral health/substance abuse services for BlueCare Plus members should call the appropriate Provider Service line listed below, or BlueCare Plus Utilization Management, 1-866-789-6314 Monday through Friday, 8 a.m. to 6 p.m. (ET). Primary Care Providers can also call our toll-free primary care provider consultation line, staffed by BlueCare Plus Peer Advisors who are Board Certified Psychiatrists. The staff is available for telephone consultation regarding all aspects of mental health and substance abuse treatment, to include medications. This service is available Monday through Friday, 9 a.m. to 5 p.m. (ET). Please call 1-877-241-5575 and identify yourself as a BlueCare Plus primary care provider seeking psychiatric consultation services.

In the event of a crisis, BlueCare Plus members and providers can call the State of Tennessee crisis hotline at 1-855-274-7471 for direction to their local crisis team for assistance. For urgent situations, members will be referred to providers in their community that can see them within forty-eight (48) hours.

K. Dental

BlueCare Plus members have coverage for the following dental services:

- Up to two routine oral exams (1 standard exam per 6 month period)
- Up to two teeth cleanings per year (1 cleaning per 6 month period)
- One emergency exam per 12 month period
- One set of dental X-rays per year (one bit wing per 12 month period; one panoramic or full mouth x-ray per 36 months)
- Fillings
- Extractions
- Dentures

BlueCare Plus also covers Medicare-covered dental services which are limited to surgery or the jaw or related structures that would be provided by a physician. Covered services are limited to:

- Surgery of the jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease
- Services that would be covered when provided by a physician
L. Therapeutic Shoes for Diabetics

BlueCare Plus provides benefits for the following when the need for therapeutic shoes is certified by a physician:

- Custom-molded shoes (no more than one pair including inserts provided with shoes and two additional pairs of inserts)
- Depth shoes (no more than one pair of depth shoes and three pairs of inserts (not including non-customized removable inserts provided with shoes)
- Inserts

M. Preventive Services

BlueCare Plus covers preventive services including:

- Abdominal aortic aneurysm one-time screening for individuals at risk
- Alcohol misuse counseling
- Bone mass measurement every 24 months for individuals at risk
- Breast cancer screening (mammogram)
  - One baseline mammogram between ages 35 and 39
  - One screening mammogram every 12 months for women age 40 and older
  - Clinical breast exam once every 24 months
- Cardiovascular disease screening
  - One visit per year with PCP for risk reduction
  - Blood testing to detect cardiovascular disease once every five years (60 months)
- Cervical and vaginal cancer screening
  - Pap tests and pelvic exams once every 24 months
  - Pap test every 12 months for any one of these:
    - High risk of cervical or vaginal cancer
    - Childbearing age
    - Had an abnormal Pap test within the last three years
- Colorectal screening
  - Age 50 or older flexible sigmoidoscopy or barium enema every 48 months
  - Guaiac-based fecal occult blood test or fecal immunochemical test every 12 months
  - DNA based colorectal screening every three years
  - High risk of colon cancer - Screening colonoscopy or barium enema every 24 months for individuals
  - Not at high risk of colon cancer – screening colonoscopy every 10 years (120 months) but not within 48 months of screening sigmoidoscopy
- Depression screening one per year in a primary care setting
- Diabetes screening including fasting glucose test for any of the following risk factors:
  - Hypertension
  - History of dyslipidemia
  - Obesity
  - History of high blood glucose
  - Based on results of these screenings, member may be eligible for up to two diabetes screenings every 12 months
- HIV screening
Individuals who ask for screening test or at high risk for HIV infection one screening exam every 12 months
Women who are pregnant up to three screening exams during pregnancy
Medical nutrition therapy services for individuals with any of the following:
- Diabetes
- Renal disease not on dialysis
- Post kidney transplant
Medicare Diabetes Prevention Program
Obesity screening and counseling
Prostate cancer screenings (PSA)
Screening and counseling to reduce alcohol misuse
Screening for lung cancer with low dose computed tomography (LDCT)
- Eligible members ages 55-77 who have no sign of lung cancer but history of smoking at least 30 packs per year and currently smoke or have quit in the past 15 years
- Once every 12 months
Tobacco use cessation counseling
Vaccines, including influenza, hepatitis B and pneumococcal
Welcome to Medicare preventive visit (one-time)
Yearly Wellness visit

### N. Hearing Services

Routine hearing exams, hearing aid fittings/evaluations, hearing aids, and hearing aid repairs/adjustments with an annual coverage limit of $1000.

### O. Over the Counter (OTC)

Coverage limit of $192 every three months for OTC medications and items such as bandages, toothpaste, etc.

### P. Podiatry Services

Diagnosis and medical or surgical treatments of injuries and diseases of the feet, and routine foot care for members with certain medical conditions affecting lower limbs.

### Q. Cardiac Rehabilitation Services

Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Two one-hour sessions per day for up to 36 sessions per service per year are covered.
R. Pulmonary Rehabilitation Services

Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a doctor’s order from the treating physician. BlueCare Plus covers 36 sessions with an additional 36 sessions if medically necessary.

S. Transportation

BlueCare Plus covers 40 one-way trips for covered medical, dental, vision, and hearing appointments and non-emergent transportation.

T. Vision Services

BlueCare Plus members have coverage for:
- One routine eye
- One glaucoma screening each year for members at high risk
- Diabetic retinopathy screening one time per year for members with diabetes

U. Health and Wellness

- Telephonic and face to face coaching (in some circumstances)
- SilverSneakers® Fitness Center membership
- A 24 hour nursing hotline
- Home-based monitoring for CHF, COPD, diabetes, and uncontrolled hypertension
V. Non-Covered Benefits

A. Overview

General exclusions from coverage for certain items or services for which BlueCare Plus cannot pay claims include:

- Not reasonable and necessary
- No legal obligation to pay for or provide (will be paid by other entity)
  - Automobile insurance;
  - No-fault insurance;
  - Liability insurance; or
  - Workers’ Compensation (WC) law or plan of the U.S. or a State.
- Paid for by governmental entity
- Not provided within United States
- Resulting from war
- Personal comfort
  - Items that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member
  - Examples: Items such as radio, television, telephone, air conditioner, and beauty and barber services
- Routine services and appliances unless covered as a supplemental benefit and described above in the coverage section
- Custodial care
  - Personal care that does not require continued attention of trained medical or paramedical personnel
  - Assistance in walking, getting in and out of bed, bathing, dressing, feeding, using toilet, preparation of special diets, and supervision of medications that usually can be self-administered
- Cosmetic surgery and expenses incurred in connection with cosmetic surgery
- Charges by immediate relatives or members of household
- Paid or expected to be paid under worker’s compensation
- Non-physician services related to and required as a result of services which are not covered under Original Medicare
- Excluded foot services and supportive devices for feet
  - Treatment of flat foot
  - Routine foot care such as removal of corns or calluses
  - Orthopedic shoes unless for a member with diabetes or if an integral part of a leg brace
- Excluded investigational devices
- Self-administered drugs - BlueCare Plus adheres to the Cahaba Government Benefit Administrators, LLC Self-Administered Drug (SAD) Exclusion List.
The non-covered benefits listing contained in this section is not an all-inclusive list. It is intended to be a general summary and does not take place of regulations and plan requirements. Refer to IOM Medicare Benefit Policy Manual Publication 100-02 Chapter 16.

B. Services and Supplies Denied as Bundled or Included in the Basic Allowance of another Service

Services and supplies that are bundled or included in the basic allowance of another service will not be paid.

- Fragmented services included in the basic allowance of the initial service;
- Prolonged care (indirect);
- Physician standby services;
- Case management services (e.g., telephone calls to and from the beneficiary); and
- Supplies included in the basic allowance of a procedure.
VI. National Coverage Determinations (NCDs)

Local Coverage Determinations (LCDs) and Correct Coding Initiative (CCI)

A. Overview

The Centers for Medicare & Medicaid Services (CMS) implements policies through the national coverage decision (NCD) process. NCDs are national policies on the coverage of specific medical services. Both the local and the national coverage processes explicitly consider whether services meet Medicare’s statutory requirements for “reasonable and necessary” care.

The statutory and policy framework within which National Coverage Decisions (NCDs) are made may be found in title XVIII of the Social Security Act (the Act), and in Medicare regulations and rulings. In general, the Act lists categories of items and services covered by Medicare, although Congress occasionally adds specific services to be covered by Medicare.


The organization of the NCD manual is by categories, e.g., medical procedures, supplies, diagnostic services. Provided at the beginning of the manual is a table of contents designating coverage decision categories. Each subject discussed within the category is listed and identified by a number and is located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part1.pdf.


BlueCare Plus abides by The CMS payment policies and NCDs. In the absence of an NCD BlueCare Plus abides by applicable Local Coverage Determinations (LCDs). LCDs are specific written policies made by the Medicare Administrative Contractor (MAC) with jurisdiction for each individual State. In the absence of an applicable NCD, LCD, or other CMS published guidance, BlueCare Plus develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.
BlueCare Plus Utilization management program follows the CMS hierarchy for both decisions and references in making medical necessity determinations as discussed in Section XII Utilization Management of this manual.

B. Correct Coding Initiative Overview

CMS developed the National Correct Coding Initiatives (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Medicare Part B claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, Healthcare Common Procedure Coding System (HCPCS) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. Updated NCCI edits are published on The CMS website on a quarterly basis.

Code bundling edits are performed during the initial claim processing phase, when possible, and are based on nationally recognized code bundling guidelines including:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare and Medicaid (CMS) guidelines
- Guidelines published by medical societies/associations such as the American Academy of Orthopedic Surgeons (AAOS) and American College of Obstetricians and Gynecologists (ACOG)
- Clinical rationale/expertise
- BlueCare Plus code bundling rules are also based on reimbursement policies such as, but not limited to, the following:
  - Bundled Services regardless of the Location of Service
  - Bundled Services when the Location of Service is the practitioner’s Office
  - Durable Medical Equipment (Purchase and Rentals)
  - Home Pulse Oximetry
  - Screening Test for Visual Acuity
  - Visual Function Screening
  - Quarterly Reimbursement Changes

Edits may be applied when all associated claims are processed in some situations. In those cases, the edit will be applied during the retrospective audit process when all associated claims are available for review. The Column One/Column Two Correct Coding Edits table includes code pairs that should not be reported together for a number of reasons. Code bundling rules reflect edits where a comprehensive and component code pair exists.

C. Column 1/Column 2 Code Pair Tables
The column 1/column 2 correct coding edit table contains two types of code pair edits. In the "Comprehensive Code" edits table, the column 1 code generally represents the more significant procedure or service when reported with the column 2 code. When reported with the column 2 code, "column 1" generally represents the code with the greater work RVU of the two codes. The "Mutually Exclusive" edit table contains code pairs that Medicare believes should not be reported together where one code is assigned as the column 1 code and the other code is assigned as the column 2 code. If a provider submits two codes of a code pair edit for the same Medicare beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a NCCI/CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed. Below is an example of the coding edit table.

![Column 1/Column 2 Edits Table]

Note: The example above is an excerpt from the CMS CCI code table located at [www.cms.gov](http://www.cms.gov).

Although the Column 2 code is often a component of a more comprehensive Column 1 code, this relationship is not true for many edits. In the latter type of edit the code pair edit simply represents two codes that should not be reported together, unless an appropriate modifier is used.

**Comprehensive (Column 1) code** generally represents the major procedure or service when reported with another code.

**Component (Column 2) code** generally represents the lesser procedure or service. Reimbursement for a component code is considered included in the reimbursement for the comprehensive code when the service is billed by the same provider, for the same patient on the same date of service and is not made separately from the comprehensive code.

Code bundling can occur on multiple levels depending on the combination of codes reported. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code. Providers can access the most current code bundling rules for code pairs via The Centers for Medicare & Medicaid Services (CMS) [http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html](http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/NCCI-Coding-Edits.html). The page provides hospital and physician CCI edits.
VII. Pharmacy

In addition to coverage for Part D drugs, BlueCare Plus also covers some drugs under the plan’s medical benefits:

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections given during an office visit and drugs given at a dialysis facility.

- BlueCare Plus covers drugs given during covered stays in the hospital or in a skilled nursing facility.

In addition to the drugs covered by Medicare, some prescription drugs are covered for BlueCare Plus members under Medicaid benefits. The member may contact Medicaid for more information about drugs covered under their Medicaid coverage.

BlueCare Plus will generally cover drugs under these basic rules:

- The member must have a network provider write the prescription
- The member must use a network pharmacy to fill prescriptions
- The drug must be on the plan’s List of Covered Drugs (Formulary)
- The drug must be used for a medically accepted indication.
  - Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
  - Or -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

BlueCare Plus offers a “List of Covered Drugs (Formulary)” available on the BlueCare Plus Website at bluecareplus.bcbst.com.

The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The meets requirements set by Medicare. Medicare has approved the plan’s Drug List.

A. Overview and Prior Authorization

Certain drugs with special indications require authorization. These drugs are noted on the formulary. For BlueCare Plus the prescribing practitioner is responsible for obtaining the necessary authorization, drugs that require a prior authorization are noted on the formulary. Prior authorization must be obtained before the drug is dispensed. You may request prior authorization by contacting the following:

Y0013_W14_P2
BlueCare Plus HMO DSNP
Customer Service for Members 1-800-332-5762
Fax 1-888-725-6849
Website http://bluecareplus.bcbst.com
TTY Users call: 711

Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. These drugs are noted on the formulary. Greater quantities require practitioner request for Medical Necessity by calling 1-800 299-1407.

Redetermination

If Express Scripts has made an adverse determination for a medication or pharmaceutical product, the member or the member’s physician may initiate a pharmacy redetermination.

Express Scripts has made an adverse determination and denied a member’s request for coverage of (or payment for) a prescription drug, a member has the right to ask for a redetermination (appeal) of our decision. A member has 60 days from the date of the Notice of Denial of Medicare Prescription Drug Coverage to ask for a redetermination. Request for Redetermination of Prescription Drug Denial is available and may be sent by mail or fax:

Address:
Express Scripts 1-888-235-8551
Attn: Medicare Reviews
P.O. Box 630367
Irving, TX 75063-0118

A member may also ask for an appeal through the website at bluecareplus.bcbst.com. Expedited appeal requests can be made by phone at 1-877-916-2271.

Who May Make a Request: The prescriber may ask for an appeal on the member’s behalf. If a member wants another individual (such as a family member or friend) to request an appeal for the member, that individual must be the member’s representative. Contact us to learn how to name a representative.

Pharmacy Directory
BlueCare Plus Pharmacy Directory is available on the BlueCare Plus Website.

Formulary Exceptions
An exception is a type of coverage determination that is unique to the Part D benefit. A member, member’s authorized representative or member’s prescribing physician may request a Tiering Exception or a Formulary Exception.

Y0013_W14_P2
Formulary Exception

Ensures that members have access to medically necessary Part D drugs that are not included on the BlueCare Plus formulary. Also permits member to request an exception to a quantity or dose limit or a requirement that the member try another drug before BlueCare Plus will pay for the requested drug.

The Physician’s supporting statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because:

- All covered Part D drugs on any tier of the BlueCare Plus formulary would not be as effective for the member as the non-formulary drug, and/or would have adverse effects;

- The number of doses available under a dose restriction for the prescription drug:
  - Has been ineffective in the treatment of the member’s disease or medical condition or,
  - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance; or

- The prescription drug alternative(s) listed on BlueCare Plus is required to be used in accordance with step therapy requirements:
  - Has been ineffective in the treatment of the member’s disease or medical condition or, based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance; or
  - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause and adverse reaction or other harm to the member.

The review process for a tiering exception or formulary exception request will not begin until BlueCare Plus receives the Physician’s supporting statement.

The Physician’s supporting statement will be evaluated based on:

- Comparisons of quality of the particular medication therapy, including safety, efficacy, effectiveness and cost, as well as, comparison of the drug product within the specific therapeutic class, and

- Medical evidence, such as, peer reviewed medical references, primary research, standards of practice, or relevant findings of government agencies, medical associations, and national commissions.

To request a formulary exception, complete a Medicare Part D Prescription Drug Authorization
Request for refill:

If an exception is granted, BlueCare Plus cannot require the member to request approval for a refill or new prescription to continue using the Part D prescription drug that was approved under the tiering exception and formulary exception process. Approval is for the remainder of the plan year so long as the member remains enrolled in the Plan, the Physician continues to prescribe the drug and it continues to be safe for treating the member’s condition. For tiering and/or formulary changes during the benefit year resulting in a member’s drug no longer being covered, the affected members will be notified by letter at least 60 days prior to the effective date of such changes. Members may request an appeal of any formulary change BlueCare Plus will review the request according to the tiering exception and formulary exception process. Express Scripts will review all requested drugs for formulary status, and for further consideration of formulary placement.

B. Identification Card (ID)

Every BlueCare Plus plan member receives a BlueCare Plus ID card reflecting the benefit plan and product for the member enrolled. The ID card provides the following information:

- Member name
- Member ID number
- Drug coverage indicator

Providers can verify the member’s BlueCare Plus ID plan by simply checking his/her member ID card. When a BlueCare Plus member presents to your office, please take a moment to look at the card to help prevent members from being denied services incorrectly.

Sample copy of BlueCare Plus ID Card

Identifies the Part D Prescription Group and ID number
VIII. Model of Care (MOC) D-SNP

A. Overview

BlueCare Plus offers a Special Needs Plan (SNP) for our dually eligible members that have Medicare Part A and Part B and are Medicaid qualified.

B. SNP Target Population

The Dual eligible population includes those individuals with diverse needs, and requires a blend of medical, long-term, care, behavioral health and social services. This population will receive fully integrated physical and behavioral health services designed to serve the individual needs of this population. Medicare and Medicaid eligible members will receive a seamless continuum of care through BlueCare Plus’ Care Coordination process.

C. Model of Care Overview

Our Model of Care is designed to serve the unique individual needs of the dual eligible Medicaid and Medicare population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs.

Our Model of Care focuses on:

- Care coordination across settings and providers and seamless transitions of care and coordination with Medicaid MCOs for Medicaid services
- Inpatient care coordination with an emphasis on effective discharge planning and post-discharge follow-up to reduce the likelihood of readmissions
- Nursing facility care coordination including services for members receiving inpatient hospice and in long-term care facilities
- Home and Community-Based Services care coordination including long-term home health and private duty nursing services
- Services for members with complex chronic conditions with a concentration on evidence-based care, medication management and monitoring access to care
- Preventive and health promotion services
- Health outcomes
- Quality of life

Our model of care includes:

- A member centric Interdisciplinary Care Team (ICT) consisting of health plan medical and behavioral health clinical professionals, members and his or her caregivers, Primary Care Physicians (PCP), specialty physicians, and other providers caring for frail and chronically ill
members. The ICT will be the primary facilitator of care management to ensure efficiency and continuity of services. The comprehensive team of health care professionals will develop and implement an individualized care plan to address a member’s medical, behavioral health, psychosocial and long-term care needs.

- A single point of contact BlueCare Plus clinician to improve care coordination and care transitions and will be responsible for engaging members to participate in his or her ICT and developing an individualized plan of care.
- Clinical programs built on evidence-based medicine and proven programs within our health plan that have well-planned outcomes reporting for continuous quality improvement.
- A structured Model of Care training program for network providers to ensure application of integrated care management strategies.

D. Staff Structure and Care Management Roles

BlueCare Plus has a multi-disciplinary Care Coordination Team who administers care management activities. The non-clinical staff coordinates benefits, plan information, conducts member outreach, and obtains data from members and network providers. Registered nurses and licensed behavioral health staff perform clinical functions; maintaining a coordinated care management process, education and clinical care. Both non-clinical and clinical staff monitors the Model of Care compliance, assuring statutory and regulatory compliance and monitoring care management effectiveness to provide a coordinated plan of care for each member.

E. Specialized Provider Network

Coordinating the MOC and care management requires a specialized provider network. BlueCare Plus ensures providers are actively licensed and competent. As well as informed of statutory and regulatory compliance and participating in the Interdisciplinary Care Team (ICT) for the BlueCare Plus members to deliver specialized services in a timely and quality manner, providers are expected to use evidence-based clinical practice guidelines and nationally recognized protocols. For additional information for participating in BlueCare Plus visit our website, bluecareplus.bcbst.com.

Credentialing occurs initially during the application process for any provider applying to participate in the BlueCare Plus Network. Once a provider is approved to participate in the network, they must be re-credentialed based on the service types each provider provides. The credentialing process assures that licensed physicians, organizations, and other health care practitioners within the provider network are qualified to provide health care services to BlueCare Plus members.

Network providers are educated on the coordination of Medicare and Medicaid benefits for which members are eligible. Providers are contractually required to complete the Model of Care (MOC) training. BlueCare Plus offers a self-study and attestation through the BlueCare Plus Website. The attestation must be submitted for verification of the annual MOC training. Annual MOC training will be in print form and available through Provider Resources section of the BlueCare Plus Website. If
additional training is identified, the Corporate Provider Relations Network Managers and/or BlueCare
Plus’ Provider Representative through telephonic outreach will conduct the training or face-to-face
provider visits.

BlueCare Plus will not interfere with health professional advice to members regarding member’s care
and treatment options, as documented and communicated to providers in the BlueCare Plus Provider
Administration Manual.

BlueCare Plus encourages open patient communication regarding appropriate treatment alternatives.
Providers are not penalized for discussing medically necessary or medically appropriate care with
patients.

F. New Provider Orientation and Training

New provider orientation and training will be provided after the completion of contracting and
credentialing. The provider will be sent a welcome letter with the effective date and the network
manager assigned. The welcome letter includes online resources and a link to this Provider
Administration Manual. This manual serves as a source of information for BlueCare Plus.

BlueCare Plus offers training that is tailored to the needs of those providers and billing staff that
provide services to the dually eligible members. The training offers fundamental Medicare policies,
programs, and procedures and with a concentration on and information on billing BlueCare Plus.

G. Provider Education and Ongoing Training

BlueCare Plus offers a provider service program to assist providers in understanding and complying
with the operational processes, policies and billing procedures for the dually eligible population. The
outreach program serves to strengthen and enhance ongoing efforts to continuously improve provider
satisfaction through timely delivery of accurate and consistent information. The provider outreach
will enable providers to understand, manage and bill BlueCare Plus correctly thus reducing the paid
claims error rate and improper payments.

The provider outreach area utilizes a variety of strategies and methods to offer providers a broad
range of information regarding the BlueCare Plus program. Methods include print, the provider
resources section of the website at bluecareplus.bcbst.com, face to face instruction, web based
training and presentations.

BlueCare Plus (HMO DSNP)™ updates and/or changes are communicated through the BlueAlert
Newsletter published monthly and/or the quarter Provider Administration Manual (PAM releases).

H. Health Needs Assessment
At enrollment, BlueCare Plus identifies a member’s health status through an initial health needs assessment (HNA). The assessment identifies medical, psychosocial, functional, behavioral, and cognitive needs of the member within 90 days of enrollment, again at least annually and with any change in the member’s health status. BlueCare Plus clinical Care Coordinators use this information to analyze and stratify a member’s risk level, and then develop an individualized care plan. This information is shared with the member’s individual Interdisciplinary Care Team (ICT) for further analysis and stratification. The ICT should include the Primary Care Provider (PCP) and other treating providers to facilitate collaboration with all providers who are treating that member. See section J for additional ICT information.

I. Individualized Care Plan (ICP)

Each BlueCare Plus member has an individualized care plan developed by clinical staff. A written plan of care is mailed to a member’s PCP for input and revision to the member’s ICP. Any revisions to the ICP should be returned to BlueCare Plus via telephone, writing or fax. The written ICP prepared by BlueCare Plus and submitted to a PCP is intended to assist the PCP in obtaining necessary information and helping to coordinate and manage his or her member.

The member and/or caregiver will receive a copy of the care plan as well; our hope is that this single document reflects the entire continuum of the member’s health care needs and services. Additionally, as applicable, other treating providers will be issued a copy of the written ICP.

J. Interdisciplinary Care Team (ICT)

Each member will have his or her own personal Interdisciplinary Care Team (ICT). A member’s PCP is a crucial component of the member’s ICT. At the center of the ICT are the member and/or caregiver(s), the PCP, Care Coordinator, and based on the members’ expressed needs, preferences, clinical condition, and/or living situation, the ICT expands to include appropriate professionals and community supports.

PCP/providers and other ICT participants, if applicable, may participate through the methods listed below:

- Return of the Patient Assessment and Care Planning Form (PACF)
- Medical records submitted in response to the PACF
- Medical records obtained during care management activities
- Receipt of a mailed hard copy of the member’s individualized ICP
- Returned response to mailed ICP
- UM authorization clinical information including physician orders/plan for services
- Receipt of a mailed hard copy authorization letter
- Face to face with a member during a physician office visit
- Information obtained by the Care Coordination Team during a conversation with a provider’s office or a facility discharge coordinator
- Information obtained by the embedded Patient Center Medical Home Care Coordinator

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The purpose of the ICT is to ensure appropriate communication related to a member’s health and health care needs that results in:

- Better coordination of services for the member
- Enhanced member understanding
- Informed decision-making
- Safer medication practice
- Better adherence to prescribed medication
- Better self-management of chronic disease
- Reduced hospitalizations or readmissions

BlueCare Plus will reimburse the PCPs for each ICT they participate in via one of the methods described above. PCPs may use the following codes for claims submission for ICT participation.

99366 - Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional
99367 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional

If the PCP participates and the patient is in the office, the PCP should also bill the appropriate office visit evaluation and management code (e.g., 99211 through 99215).

The BlueCare Plus Medical Director and Care Coordinators conduct case rounds at least monthly to evaluate the health status of members who need immediate attention or have complex health issues and to discuss health care options. PCPs and other treating providers may be contacted to participate in case rounds if necessary.

K. Performance and Health Outcome Measurement

BlueCare Plus collects, evaluates, analyzes and reports performance and outcome measurements for the D-SNP program. Internal quality specialists continually review the outcomes to enhance and improve the MOC. Communication of these improvements and updates are published through the BlueAlert, BlueCare Plus Website, Provider Quality newsletters and announcements. BlueCare Plus utilizes an electronic messaging system and the Provider website to keep providers up to date with changes and enhancements. Additionally, BlueCare Plus will include the Medicare Health Outcomes Survey (HOS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the Healthcare Effectiveness Data and Information Set (HEDIS) and The Center for Medicare & Medicaid STARS to measure in evaluating, analyzing and improving the BlueCare Plus program.
Established quantitative measures evaluate performance for issues identified in the HRA, Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT) and the MOC. Each measure is objective, quantifiable based on current scientific knowledge and has an established goal and/or benchmark. These measures may include Health Effectiveness Data and Information Set (HEDIS) Effectiveness of Care measures; Use of Services measures; measurement of outcomes related to approved plan clinical practice guidelines or chronic condition management systems, or other issues that are relevant to the population. This provides BlueCare Plus an objective means to help identify special populations, geographical needs, identify trends and help prioritize opportunities. BlueCare Plus will continue to review performance and outcomes to enhance the Health Risk Assessment and Model of Care to improve and strengthen the program. For additional information and updates visit http://bluecareplus.bcbst.com/provider-resources.

L. Integrated Communication Network

BlueCare Plus coordinates the delivery of services and benefits through integrated systems of communication among plan personnel, providers, and members. Our communication structure includes; web-based network, audio conferencing and face-to-face meetings. Included in the provider resources is a request form for additional training. Training is provided as feasible through different methods; web conferencing, telephone conferencing and on site as permitted. The website will be the preferred method of communication for updates and changes for both the member and provider.

M. Measurable Goals

Measurable goals are identified and reviewed for optimum care for BlueCare Plus members. BlueCare Plus has outlined the goals below in accordance with The Centers for Medicare & Medicaid (CMS) guidelines for program management:

- Improving access to essential services such as medical, mental health, and social services;
- Improving access to affordable care;
- Improving coordination of care through an identified point of contact;
- Improving seamless transitions of care across healthcare settings, providers, and health services;
- Improving access to preventive health services;
- Ensuring appropriate utilization of services; and
- Improving beneficiary health outcomes.

BlueCare Plus uses evidence-based guidelines to set and achieve care management goals and the structure of the Care Management program was designed based on the SNP structure and process measures developed by the National Committee for Quality Assurance (NCQA) and CMS’ Special Needs Plans model and requirements.
BlueCare Plus periodically analyzes and evaluates the rate of progression toward goals by identifying and addressing any barriers impeding goal achievement and identifying opportunities for improvement. The program was designed to assure members have access to essential, affordable and cost effective care based on continual assessment and measurable outcomes.

N. Model of Care Process Summary

In summary, following enrollment of the member with BlueCare Plus plan, a health needs assessment will be conducted and the information will be used to design coordinated care for special needs members through an interdisciplinary care team (ICT) and an individualized plan of care.

The purpose of the ICT is to consistently collaborate to solve a member’s health care problems that may be complex to provide for efficient health care. As a health care provider for a BlueCare Plus member, you will be required to participate in an individual member’s ICT on an annual basis. The ICT is responsible for analyzing the results of the initial and annual health risk assessments and incorporating those findings into an individualized plan of care, collaborating to develop and, at least annually, update the member’s plan of care, and managing the physical and behavioral health, functional and social support needs of the member. BlueCare Plus will make every effort to have the member participate in his or her ICT, if feasible.

To contact BlueCare Plus for additional information call the numbers below:

Provider Contact  1- 800 299-1407  
Members Contact  1- 800 332-5762
IX. Care Management

A. Overview

The Care Management Program managed by the Population Health Management Department, provides the following services:

- Discharge/transition management
- Care Coordination
- Condition-specific management programs as indicated coronary artery disease, congestive heart failure, diabetes, chronic obstructive pulmonary disease and asthma
- Telemonitoring for members with congestive heart failure or chronic obstruction pulmonary disease and on oxygen
- Complex Care Management
- Transplant Care Management
- End of Life Planning
- Catastrophic Care Management

Care management focus on the most vulnerable members who:

- Are frail with functional limitations
- Have mental, cognitive or physical disabilities
- Have end-stage renal disease
- Are near end of life
- have multiple and chronic medical conditions complicated by mental health issues, such as depression, bipolar disorder, schizophrenia or dementia, or social issues such as homelessness, or lack of adequate supports

B. Referrals and Triage

Members, family and/or caregivers, practitioners and providers are encouraged to initiate referrals for any of the above listed programs and services. A Care Management team member, such as a registered nurse or behavioral health clinician will contact the designated person upon receipt of the referral.

C. Discharge Planning/Transition of Care

CMS requires BlueCare Plus to assist with discharge planning and transition of care for all members transitioning to a different setting. BlueCare Plus prioritizes its focus on assisting with transitions for inpatient services including:

- Medical and Behavioral Health inpatient admissions
- Long-term Acute Care admissions
- SNF admissions
• Inpatient Rehabilitation admissions

The Division of TennCare also requires BlueCare Plus to perform specific transition activities for CHOICES members in an acute inpatient facility.

It is extremely important for BlueCare Plus Care Management Department to be notified of discharge plans and the discharge date for all BlueCare Plus members for timely intervention by the BlueCare Plus Care Coordinator upon discharge.

The role of the Care Coordinator is to assist the PCP or other treating providers manage transitions by coordinating follow-up care and services, assuring timeliness of services throughout the transition process, conduct medication reconciliation, ensure a member has a post-admission follow-up physician visit, and educate the member on self-management activities and tips to avoid re-hospitalization.

If during a transition of care, a member needs Medicaid services, the BlueCare Plus Care Coordinator will coordinate with the Medicaid MCO Care Coordinator to arrange for those services. BlueCare Plus also sends electronic notification to each Medicaid MCO regarding BlueCare Plus acute inpatient admissions.

As required by CMS, as a result of a transition, a member’s ICP will be updated related to the condition for which he or she was in the hospital and a copy will be mailed to the member or caregiver, PCP, and other treating providers as necessary.

D. Care Coordination

Care coordination services involve the full spectrum of care coordination. Care Coordination is intended to stabilize members’ health condition/disease, promote self-management by providing tools and education to allow them to make informed decisions about their health care, encourage and provide tools for active participation in managing their condition(s), and assist with arranging for care in the most appropriate setting and care that is necessary for self-management. Providers are encouraged to make referrals to the program.

Care Coordination also includes both the determination for admission and need for concurrent review (as explained under the Concurrent Review section of this Program Description) for any Skilled Nursing Facility (SNF). As with the Utilization Management Program, this Health Management program adheres to CMS Medicare Advantage rules and regulations promulgated in 42 CFR-422, CMS Internet Only Medicare Managed Care Manual and NCQA’s Special Needs Plans Structure and Process Guidelines.

The coordination of members’ care is essential for healthy outcomes. If you are the Primary Care Provider (PCP), remember to ask the member if they have been seen by any other providers since they were last seen, encourage the member to discuss treatment plans received elsewhere as well as requesting the information from the other provider.

If you are the member’s specialist or other treating provider, obtain the name of the member’s PCP and share medical assessments, prescriptions, or treatment provided by the member’s PCP.
E. Condition-Specific Management Programs

Condition-specific management programs involve the same concepts as care coordination; however, it is disease specific. It is a system of coordinated health care interventions and communications for the population's members with conditions in which patient self-care efforts are significant. These programs emphasize prevention of exacerbations and complications through education and monitoring, and evaluation of clinical outcomes on an ongoing basis with the goal of overall health.

The disease states managed within this program are coronary artery disease, diabetes, congestive heart failure, chronic obstructive pulmonary disease and asthma (subject to change based on analysis). The primary goal is to stabilize the member’s health condition/disease and assist them with tools, education and care necessary for self-management. The program promotes member and caregiver’s active participation in management of the disease process resulting in an increased knowledge of the disease process, prevention and treatment. Additionally, the member increases their knowledge of healthy lifestyle changes and co-morbid management. The treating Physician’s involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the Physician by reinforcing education, monitoring and reporting. Providers identifying members with these diagnoses are requested to contact Care Management for referral into the program.

F. Telemonitoring

The purpose of the telemonitoring program is to reduce condition exacerbation, and unnecessary emergency room visits, inpatient admissions and readmissions. Telemonitoring for members with CHF includes monitoring daily weight gain due to fluid retention, and blood pressure and heart rate monitoring. Telemonitoring for members with COPD includes daily pulse oximetry readings and heart rate monitoring. This is a service provided for our most vulnerable members only. The Care Coordinator will work with the member and/or caregiver for setup and training on telemonitoring equipment and will monitoring daily measures.

G. Complex Care Management

Care management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes. Members with complex health care needs, unstable multi-disease states, and conditions where a longer period of management will be required are managed through Complex Care Management. Complex and catastrophic conditions such as multiple chronic conditions, trauma, AIDS, extensive burns, frequent emergency department utilization, and frequent inpatient admissions are intensively managed by continually assessing, planning, coordinating, implementing and evaluating care. By using this approach, multiple health and psychosocial needs of the member are met.

The Care Management team works with the member, treating practitioners, family members, and other members of the health care team to coordinate and facilitate an individualized plan of treatment, evaluate the member’s progress and facilitate referrals to a less intensive health management program.
H. Transplant Care Management

Transplant Management focuses on the entire spectrum of transplant care. The transplant must take place in a Medicare approved facility.

Attention to assisting and educating the members about acquisition and use of needed drugs prescribed by their Physician, with special emphasis on the Part B benefit for anti-rejection drugs is provided. It is critically important, Care Management be contacted as soon as the provider identifies the member may need an evaluation for transplant.

I. End of Life Planning

End of Life planning provides education to a member and the member’s family related to end of life choices and advance directives through the Care Coordinator and is available to all BlueCare Plus members. All members are educated on end of life choices and advance directives but due to the complexity and chronic illnesses of our most vulnerable members, this program may be utilized more frequently by this sub-population.

Upon identification that a member may need assistance with end of life planning a Care Coordinator will contact the member/caregiver and will educate the member on end of life planning including hospice services and provide support to the member and their PCP when making a decision to enroll the member into hospice. The Care Coordinator will collaborate closely with a social worker to address the needs of members participating in this program. If the member has decided to execute an advance care plan, the social worker assists the member in completing the appropriate forms. The intent of the program is to empower members to make decisions about their health care and improve their quality of living at the end of life.

J. Contact/Referrals to Above Care Management Programs

Information

Practitioners/providers are encouraged to initiate referrals for any of the health management programs by contacting BlueCare Plus Care Management.

Phone: 1-877-715-9503
Fax: 1-866-325-6694

Referral requests should include the following information:
- Requesting provider’s name and telephone number;
- Contact person and telephone number (if different from requesting provider);
- Member name;
- Member ID number and telephone number;
- Diagnosis and current clinical information;
• Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
• Reason for referral; and
• Level of urgency.

A Care Management registered nurse or behavioral health professional will contact the requesting provider upon receipt of the program referral.

K. Nursing Facility Diversion Program

BlueCare Plus has a Nursing Facility Diversion program to help allow BlueCare Plus members to continue living safely in the community and to delay or prevent placement in a nursing facility. Through this program, our care management staff will coordinate with Medicaid Managed Care Organizations to facilitate home and community-based services for members who would otherwise qualify for nursing home placement.

Through care management, our Care Coordinators identify “at risk” members for nursing home placement by assessing to determine if a member has one or more of the following on an ongoing basis:

• Transfer – incapable of transfer to and from bed, chair or toilet unless physical assistance is provided 4 or more days per week
• Mobility – requires physical assistance 4 or more days per week. Mobility is defined as the ability to walk, use mobility aids such as a walker, crutch or can or the ability to use a wheelchair if walking is not feasible
• Eating – requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth
• Toileting – requires physical assistance to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care 4 or more days per week
• Expressive and Receptive Communication – incapable of reliably communicating basic needs and wants, such as the need for assistance with toileting or the presence of pain, using verbal or written language or the member is incapable of understanding and following very simple instructions and commands such as dressing or bathing without continual intervention
• Orientation – disoriented to person or place
• Medication Administration – not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance such as reminders when to take medications, encouragement to take medication, reading medication labels, opening bottles, handing to the member and reassurance of correct dose
• Behavior – requires persistent intervention due to an established and persistent pattern of dementia-related behavioral problems such as aggressive physical behavior, disrobing or repetitive elopement
• Skilled Nursing or Rehabilitative Services – requires certain daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than, for practical purposes, would be provided through a daily home health visit
Our Care Coordinators conduct thorough assessments of members’ functional and cognitive status as well as social supports, home environment, financial status and medication administration abilities. Close monitoring of transition of care activities is crucial in preventing unnecessary nursing facility stays. Community resources are essential in keeping a member in the community as well as ongoing assessment of the caregiver to determine efficacy for managing the member’s home needs.
X. Utilization Management

A. Utilization Management Guidelines

BlueCare Plus adheres to CMS’ Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS’ Internet Only Medicare Managed Care Manual Publication 100-16 Chapter 13l. CMS’ requirements for Medicare Part C vary from the requirements for Original Medicare.

These utilization management strategies are additional effective mechanisms for identifying members who may benefit from Care Management. The Utilization Management program follows the CMS hierarchy for both decisions and references in making Medical Necessity determinations.

BlueCare Plus coverage and payment is contingent upon the following:

1. A service must be a covered benefit in a member’s Evidence of Coverage;
2. A service must not be excluded; and
3. A service must be appropriate and medically necessary.

BlueCare Plus uses the following hierarchy of references to determine coverage:

- The law (Title 18 of the Social Security Act);
- The regulations (Title 42 Code of Federal Regulations (CFR) Parts 422 and 476);
- National Coverage Determinations (NCDs) Manual Publication 100-03 of Medicare’s Internet Only Manuals;
- Benefit Policy Manual Publication 100-02 of Medicare’s Internet Only Manuals;
- Local Coverage Determinations (LCDs);
- Coverage guidelines in Interpretive Manuals (Medicare’s Internet Only Manuals, sub-manuals) including:
  - Claims Processing Manual Publication 100-04;
  - Program Integrity Manual Publication 100-08;
  - Quality Improvement Organization Manual Publication 100-10;
  - Medicare Managed Care Manual Publication 100-16;
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC);
- Associated Program Safeguard Contractor (PSC) Local Coverage Determinations;
- MCG criteria;
- BlueCross Utilization Guidelines;
- U.S. Food and Drug Administration approved indications for medications;
- Supplemental benefits and limitations as outlined in a member’s Evidence of Coverage:
- BCBST Policy; and
- Other major payer policy and peer reviewed literature.
B. Organization Determination

As it related to UM processes, CMS defines an organization determination as a determination of medical necessity and appropriateness of a service. Organization determinations include:

- Advance determinations
- Prior authorization determinations
- Retrospective review determinations

C. Advance Determination

A member or provider has the opportunity to seek a determination of coverage of services that do not require prior authorization before receiving or providing services by requesting an Advance Determination. Advance Determinations are performed to render Medical Necessity and Appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that were not reviewed prospectively may be reviewed retrospectively for medical appropriateness to determine coverage and reimbursement. Providers can obtain an Advance Determination by phone or fax. A reference number is issued when care and treatment are determined to be medically necessary and medically appropriate.

D. Prior Authorization

Participating providers are responsible for obtaining the appropriate authorizations/advance determinations. Members or their representatives may also request authorizations or advance determinations. It is not the member’s responsibility for obtaining prior authorization determinations.

Prior authorization for coverage and Medical Necessity is required for:

- All acute care medical and behavioral health facility, skilled nursing facility, rehabilitation facility inpatient admissions, and substance abuse inpatient admissions
- Part B and specialty pharmacy medications
- Durable medical equipment – for purchase or rentals if the purchase price is greater than $500
- Orthotics and prosthetics if the purchase price is greater than $200
- Speech, occupational and physical therapy
- High tech imaging
- Non-emergent out-of-network services
- Psychiatric Residential Facilities
- Detoxification Services
- Partial Hospitalization Program (PHP)
- Psychiatric Day Treatment
- Applied Behavioral Health Analysis
- Electroconvulsive Therapy
E. Prior Authorization Review

A member, designated member advocate, practitioner or facility may request a prior authorization review. However, it is ultimately the facility and practitioner’s responsibility to contact BlueCare Plus to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.

Scheduled admissions/services must be authorized up to twenty-four (24) hours prior to admission.

Prior authorization requests for emergency admissions should be submitted within twenty-four (24) hours or one (1) business day after services have started is suggested in order to facilitate referrals to the appropriate care management program.

When a request for an authorization of a procedure, admission/service is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering the care for the day(s) or service(s) that have been denied. BlueCare Plus’ non-payment is applicable to both the facility and practitioner rendering the care.

F. UM Contact Information

Notification and authorization requests should be submitted to BlueCare Plus.

Authorization, requests, advance determination requests, and observation notification may be submitted to BlueCare Plus via the following methods:

- Telephone: 1-866-789-6314
- Online: [www.bcbst.com/Availity](http://www.bcbst.com/Availity)
- Fax: 1-866-325-6698
- Mail: BlueCare Plus Utilization Management Department
  One Cameron Hill Circle, Ste 0005
  Chattanooga, TN 37402-0005

Fax forms are available on the BlueCare Plus website at: [http://bluecareplus/provider-resources/](http://bluecareplus/provider-resources/)

G. CMS Guidance for Outreach to Support Coverage Decisions
CMS requires Medicare Advantage plans to conduct appropriate outreach to obtain the necessary clinical information in order to conduct a review for medical necessity and appropriate. If clinical information is not adequate or a Medical Director has additional questions, BlueCare Plus will follow this process:

- Conduct outreach 3 times by phone and fax in an effort to obtain information
- If information was not provided during those outreach, BlueCare Plus Medical Director will issue an “Intent to Deny” fax to provide an additional opportunity to provide the information before a denial is issued
- If information is received, it will be reviewed to determine medical necessity and appropriateness and an approval or denial will be issued as appropriate
- If information is not received after the Medical Director outreach notifying provider of intent to deny, the request will be reviewed by the Medical Director using the information available to BlueCare Plus

All four (4) outreaches will be conducted with the appropriate review timeframes for standard preservice and expedited organization determinations described in section J.

H. Non-Compliance with Prior Authorization Requirements

A contracted provider is required by contract to follow utilization management processes and must obtain authorization prior to scheduled services or request authorization in the timeframes described above for unplanned services. Failure to comply within specified authorization timeframes will result in a contractual “non-compliant” denial. A request for authorization will not be reviewed if the request is “non-compliant” unless:

- A member does not provide the provider with BlueCare Plus identification card nor notify the provider he or she has a BlueCare Plus plan; or
- BlueCare Plus has not issued a coverage identification card prior to a member needing a service; or
- A coverage issue existed.

If one of the above situations occurred and a provider can provide written evidence of this, a provider can request an appeal through the Provider Dispute Resolution Procedure (PDRP) including a copy of the medical record relevant to the admission or services and the face sheet at the time of the service. At that point, a medical necessity review will be conducted. The PDRP is further described in section L.

BlueCare Plus providers cannot bill members for covered services denied due to non-compliance by the provider.

I. Retrospective Review
Prior to claims payment, select codes may require a review for medical necessity. These reviews will be performed using CMS’ hierarchy and an approval or denial of medical necessity will be issued.

### J. Review Timeframes

Organization determinations are reviewed as expeditiously as a member’s health condition requires.

**Organization determination types:**

- **Standard preservice organization determination** – determination will be made no later than fourteen (14) calendar days of receipt of request

- **Expedited organization determination** – upon request by a physician, member or member’s authorized representative and determination will be made within 72 hours of receipt of request. This does not apply to services already rendered – those type requests will be handled as a standard organization determination

Both standard and expedited review requests may be extended up to fourteen (14) calendar days if a member requests and extension or if BlueCare Plus justifies a need for additional information and that it is in the interest of the member to extend the timeframe.

- **Standard retrospective organization determinations** – within thirty (30) calendar days of receipt of request

### K. Mandated Notices

#### A. Important Message from Medicare (IM):

Hospitals are responsible to deliver the Important Message from Medicare (IM) to any BlueCare Plus member who is a hospital inpatient to inform a member of hospital discharge appeal rights.

CMS requires within two (2) calendar days of admission to a hospital to:

- Issue IM to member or member’s authorized representative
- Explain a member’s right as a hospital patient including discharge appeal rights
- Obtain signature of member or authorized representative and provide a copy to the member/representative

CMS requires within two (2) calendar days of discharge to a hospital to:

- Deliver a copy of the signed notice to the member/representative

#### B. Detailed Notice of Discharge (DN):

CMS requires a Detailed Notice of Discharge (DN) be distributed to a member or authorized representative requesting an appeal of discharge from an inpatient facility or when BlueCare Plus no
longer intends to continue coverage of an authorized hospital inpatient admission. BlueCare Plus delegates to providers the responsibility for developing and delivering the DN for provider discharge determinations and for delivery of DN for BCBST discharge determinations. CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the QIO’s notification or BlueCare Plus’ request for delivery. Providers are required to fax a signed copy of the DN to HMO D-SNP Plus UM Department at 1-866-789-6314. Providers must be able to demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.

C. Notice of Medicare Non-Coverage (NOMNC):
Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) are responsible for delivering Notices of Non-Coverage (NOMNC) to the member or the authorized member representative in accordance with applicable CMS regulations to notify a member how to request an expedited determination and provide an opportunity for such a request.

The NOMNC should be delivered at least two (2) days prior to the member’s HHA, SNF, or CORF previously approved/authorized services ending as per CMS requirements. If the member’s services are expected to be fewer than two (2) days in duration, the HHA, SNF, or CORF must provide the NOMNC to the member at the time of admission to the provider. A model NOMNC form is located on The CMS Website. Providers are required to fax a signed copy of the NOMNC to BlueCare Plus UM Department at 1-866 325-6698.

D. Detailed Explanation of Non-Coverage (DENC):
CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a member or authorized representative requesting an appeal of discharge from a SNF, HHA, or CORF or when BlueCare Plus no longer intends to continue coverage. BlueCare Plus delegates to providers the responsibility for developing and delivering the DENC for provider discharge determinations and for delivery of the DENC for BlueCare Plus discharge determinations. CMS requires the DENC to be delivered as soon as possible, but no later than close of business the day of the QIO’s notification or BlueCare Plus’ request for delivery. Providers are required to fax a signed copy of the DENC to BlueCare Plus UM Department at 1-866 325-6698. Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations. Providers are required to inform BlueCare Plus members that a request for denial notice must be submitted to BlueCare Plus by the member, in the event that the member believes that he/she is being denied service.

E. Medicare Outpatient Observation Notice (MOON)
Hospitals and critical access hospitals are required to provide a MOON to Medicare Advantage beneficiaries receiving observation services for more than 24 hours to inform them they are outpatients receiving observation services and are not patients of a hospital or critical access hospital.

- Written MOON must be provided no later than 36 hours after observations services an outpatient began
- Oral notification must consist of an explanation of the MOON
- Member or authorized representative must sign and date the MOON
L. PDRP Reconsideration Process

BlueCare Plus offers contracted providers an appeal process for services that have already been provided through BCBST’s Provider Dispute Resolution Process. The Utilization Management Department reviews PDRP reconsiderations that are received from the provider within 60 calendar days of the provider’s receipt of a denial. UM will make a determination within 30 calendar days of receiving the reconsideration request. If a denial is upheld, a provider may request a written PDRP appeal. Mail reconsideration requests to:

BlueCare Plus Utilization Management Department
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

M. Member Appeal Process

Any service that has not been provided and has been denied and appealed would go through the Medicare Member Appeals Process. Contracted providers do not have appeal rights through Medicare; however, a contracted provider may request an appeal of a denial of a service not yet rendered and CMS considers the request is on behalf of the member. See Chapter II. Section I for Member Appeals.

N. Reopening

A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

There must be new material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.

The following are guidelines for a reopening request:

- Must be made in writing;
- Must be clearly stated;
- Must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted).
XI. Billing

A. Overview

BlueCare Plus electronic claims processing system is in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This system is used for processing American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. Business edits have been modified to recognize the new ANSI formats. These edits apply to both electronic and scannable paper claims.

BlueCare Plus providers contracted with Medicare and Medicaid lines of business, serving the BlueCare Plus members will be able to take advantage of single-claim submissions. Claims submitted to BlueCare Plus will be processed under Medicare benefits through BlueCare Plus and then will automatically process under Medicaid benefits through the appropriate program.

1. Provider Number for Electronic Claims

Claims submitted electronically must include the provider’s appropriate National Provider Identifier (NPI), and the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com. Additional companion documents needed for BlueCare Plus electronic claims submission can be accessed at http://www.bcbst.com/providers/ecomm/technical-information.shtml.

2. Electronic Enrollment and Support

Enrollment of new providers, changes to existing provider or billing information (address, tax ID, Provider number, NPI, name), or any changes of software vendor should be communicated to e-Commerce via the Provider Electronic Profile form. The Provider Electronic Profile form can be downloaded at, www.bcbst.com or obtained upon request. Failure to submit a Provider Electronic Profile form when changes to electronic submission information occur can result in delays in claims payment or disruption of electronic claims submissions. Mail or Fax Provider Electronic Profile forms to:

BlueCross BlueShield of Tennessee
Attn: Provider Network Services
1 Cameron Hill Circle, Ste 0007
Chattanooga, TN 37402-0007
Fax 423-535-7523

For technical support or enrollment information, call, fax, or e-mail:

Y0013_W14_P2
3. **Electronic Data Interchange (EDI)**

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCare Plus uses the ANSI 837 version, 5010 format. American National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

4. **ANSI 837 (Version 5010)**

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*. *Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in the National Electronic Data Interchange Transaction Set Implementation Guide. This guide is available online via the Washington Publishing Company website at Additional companion documents needed for BlueCare Plus electronic claims submission can be accessed at eBusiness Technical page or the eBusiness User Guide for additional information.

5. **Submission of Paper Claims**

All network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically will ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. This effort is consistent with the health care industry's movement toward more standardized and efficient electronic processes.

Key advantages to submitting electronically are:

- Earlier payments;
- More secure submission process;
- Reduced administrative costs
- Less paper storage.
More information regarding submitting electronic claims can be found on the Providers Resource page on the BlueCare Plus Website. For assistance with BlueAccess, please contact eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 5:15 p.m., Friday 9 a.m. to 5:15 p.m. (ET), or via e-mail at eBusiness_Service@bcbst.com.

6. **Timely Filing Guidelines**

Contracted and non-contracted providers must submit all claims for medical services within one (1) year of the date of service or from the date of discharge.

BlueCare Plus will not be obligated to pay such claims filed after expiration of the applicable time period, and such claims shall not be billed to the BlueCare Plus member. BlueCare Plus will process in the normal course of its business all claims submitted by the Physician/Supplier.

BlueCare Plus generates the 277 Health Care Information Status Notification report as proof of timely filing for electronically submitted BlueCare Plus claims. The electronic claims 277CA Health Care Information Status Notification supplies providers with one comprehensive report of all claims received electronically. This report should be maintained by the provider/supplier for proof of timely filing. Providers submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox. To learn more about retrieving your electronic reports, call eBusiness Solutions at 423-535-5717, Monday through Thursday, 8 a.m. to 5:15 p.m. (ET) and Friday, 9 a.m. to 5:15 p.m. (ET).

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data or revalidating enrollment, must use Electronic Funds Transfer (EFT) to receive payments. For EFT information,

**Note:** Submission dates of claims filed electronically that are not accepted due to transmission errors are not accepted as proof of timely filing.

Carriers, physicians, and suppliers are responsible for purchasing their own Form CMS-1500 forms. Forms can be obtained from printers or printed in-house as long as they follow the CMS approved specifications (see section 30) developed by the American Medical Association. Photocopies of the Form CMS-1500 are NOT acceptable. Medicare will accept any type (i.e., single sheet, snap-out, continuous feed, etc.) of the Form CMS-1500 for processing. To purchase forms from the U.S. Government Printing Office, call (202) 512-1800.

**B. Health Insurance Form CMS-1500**
1. **Overview**

The Form CMS-1500 version 02/12 is used by health care professionals and suppliers. More instruction is available at the NUCC website for the [1500 Health Insurance Claim Form Reference Instruction Manual for Form Version 02/12](https://www.nucc.org).

A claim is a request for payment of HMO D-SNP Plus benefits for services furnished by a health care professional or supplier. Claims must be submitted within one year from the date of service and BlueCare Plus members cannot be charged for completing or filing a claim. Offenders may be subject to penalty for violations.

This section incorporates information from the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for the 02/12 Version into the BlueCare Plus Provider Administration Manual to help provide information on how to complete claim forms in compliance with Centers for Medicare and Medicaid Services (CMS) regulations. Included is a description of how each block of the CMS-1500 claim form is to be completed, what type of data should be entered, and the proper format for entering the data. Since detailed discussions or explanations of all the codes, rules and options go beyond the scope of this document, please refer any questions to BlueCare Plus. Information and codes contained herein are accurate at the time of publication. Payer-issued mailings (newsletter, bulletins, etc.), workshop sessions and Provider Network Manager visits are sources of information for keeping this manual current.

To avoid delays in receiving payments and to avoid unnecessary claim denials, it is important that all of the required information is provided in the specified formats. The CMS-1500 02/12 Version form makes it possible for payers to continue adding the use of Optical Character Recognition equipment to their claims entry operations, making faster and more accurate claim payments possible. However, incomplete data, or data not properly aligned in the proper block will be rejected by OCR equipment, creating delays in processing or the return of the claim for correction and resubmission. The following general instructions are intended to be a guide only for completing the CMS-1500 02/12 Version claim form. Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the 1500 Claim Form. The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version is available at the National Uniform Claim Committee (NUCC) Web site.

2. **General Instructions**

A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:

- Only one line item of service per claim line (Block #24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
- “Super bills,” statements, computer printout pages, or other sheets listing dates, service, and/or charges cannot be attached to the CMS-1500 claim form.
- The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is 6 lines per inch.
• The form is designated for double spacing with the exception of Blocks #31, 32 and 33, which may be single-spaced.
• Use standard fonts: do not intermix font styles on the same claim form.
• Do not use italics and script on the form.
• In completing all claim information COLOR OF INK should be as follows:
  1. Computer generated color of black
• Use upper case (CAPITAL) letters for all alpha characters.
• Do not use dollar signs ($), decimals (.), or commas (,) in any dollar amount blocks.
• Enter information on the same horizontal plane.
• Enter all information within the boundaries of the designated block.
• Extraneous data (handwritten or stamped) may not be printed on the form except to mark as “Corrected Bill”.
• Pin feed edges should be evenly removed prior to submission

Form Alignment
The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block #1 and Block #1A are 6 boxes labeled “PICA”. These boxes should be considered Line 1, Columns 1, 2 and 3, and Line 1, Columns 77, 78 and 79. Form alignment can be verified by printing “X’s” in these boxes.

Entering All Dates
In Blocks 3, 9B, and 11A please include a space between each digit. The blank space should fall on the vertical lines provided on the form.

Unless otherwise indicated, all date information should be shown in the following format:

For Blocks 3, 9B, and 11A

MMblankDDblankCCYY
MM=month (01-12)
1 blank space
DD=day (01-31)
1 blank space
CC=century (20, 21)
YY=year (00-99)

The blank space should fall on the vertical lines provided on the form. Do NOT exclude leading zeros in the date fields.
(Correct: January 1, 1924 = 01 01 24; Incorrect: 1124).

Note: New requirement for Block 24A. Omit spaces in Field 24A (date of service). By entering a continuous number, the date(s) will penetrate the dotted vertical lines used to separate month, day, and year. This is acceptable. Ignore the dotted vertical lines without changing font size.
For Block 24A

MMDDCCYY
MM=month (01-12)
DD=day (01-31)
CC=century (20, 21)
YY=year (00-99)

Listed below are field descriptions to ensure claims are processed rapidly and accurately. All services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission. The guide below is for instructional purpose only and does not guarantee payment.

3. **CMS 1500 Quick Reference Guide**

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>CMS 1500 Form Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify the applicable health insurance coverage</td>
<td><img src="image" alt="1a. INSURED'S I.D. NUMBER" /></td>
</tr>
<tr>
<td>1a</td>
<td>Enter the BlueCare Plus member identification number (required)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Enter the member’s last name, first name and middle initial as appears on the BlueCare Plus card</td>
<td><img src="image" alt="2. PATIENT'S NAME" /></td>
</tr>
<tr>
<td>3</td>
<td>Enter the patient’s birth date in the following format; MMDDCCYY and sex</td>
<td><img src="image" alt="3. PATIENT'S BIRTH DATE" /></td>
</tr>
<tr>
<td>4</td>
<td>Enter primary insurance either through the patient’s or spouse’s employment or any other source. If the insured and patient are the</td>
<td><img src="image" alt="4. INSURED'S NAME" /></td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Enter the BlueCare Plus patient’s mailing address, city, zip and telephone number (required)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>When item 4 is completed check appropriate box (conditional)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Enter insured’s address and telephone if the same as patient enter SAME (conditional)</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Check appropriate box for marital status, employed or student</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>This field may be used in the future for supplemental insurance plans.</td>
<td></td>
</tr>
<tr>
<td>9a-d</td>
<td>Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary for a Medigap policy (conditional)</td>
<td></td>
</tr>
</tbody>
</table>

same enter the word SAME.
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>CMS 1500 Form Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>10a-c</td>
<td>Check “YES” or &quot;NO&quot; to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services</td>
<td><img src="image" alt="CMS 1500 Form Example" /></td>
</tr>
<tr>
<td>10d</td>
<td><strong>Verify one number</strong>&lt;br&gt;Not required dual eligible BlueCare Plus member utilize one ID number</td>
<td><img src="image" alt="CMS 1500 Form Example" /></td>
</tr>
<tr>
<td>11</td>
<td>Provider/Supplier made good faith effort to determine who is the primary payer (required)&lt;br&gt;(See the MSP section of this manual)</td>
<td><img src="image" alt="CMS 1500 Form Example" /></td>
</tr>
<tr>
<td>11a-c</td>
<td>Additional information only if there is other insurance</td>
<td><img src="image" alt="CMS 1500 Form Example" /></td>
</tr>
<tr>
<td>11d</td>
<td>Leave blank, not required</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Patient or authorized representative signature with MMDDYY date, unless signature is on file</td>
<td><img src="image" alt="CMS 1500 Form Example" /></td>
</tr>
<tr>
<td>13</td>
<td>The patient’s signature or the statement “signature on file” in this item authorizes payment of medical benefits to the physician or supplier.</td>
<td><img src="image" alt="CMS 1500 Form Example" /></td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>CMS 1500 Form Examples</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>14</td>
<td>Date of current illness, injury or pregnancy (MMDDCCYY or MMDDYY). Chiropractic initiation of course of treatment</td>
<td><img src="https://example.com/image1.png" alt="Image" /></td>
</tr>
<tr>
<td>15</td>
<td>Leave blank. Not required.</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Date when patient is unable to work, if employed</td>
<td><img src="https://example.com/image2.png" alt="Image" /></td>
</tr>
<tr>
<td>17</td>
<td>Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.*</td>
<td><img src="https://example.com/image3.png" alt="Image" /></td>
</tr>
<tr>
<td>17a</td>
<td>Leave blank</td>
<td></td>
</tr>
<tr>
<td>17b</td>
<td>Enter NPI of referring/ordering physician from item 17</td>
<td><img src="https://example.com/image4.png" alt="Image" /></td>
</tr>
<tr>
<td>18</td>
<td>Enter date when a medical service is furnished as a result of, or subsequent to, a related hospitalization (MMDDYY or MMDDCCYY)</td>
<td><img src="https://example.com/image5.png" alt="Image" /></td>
</tr>
<tr>
<td>19</td>
<td>Enter date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Complete when billing for diagnostic tests subject to</td>
<td><img src="https://example.com/image6.png" alt="Image" /></td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>CMS 1500 Form Examples</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>anti-markup payment limitation</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Enter patient’s diagnosis/condition. Code to the highest level of specificity for date of service (DOS) in priority order, version 02/12 accommodates ICD-10-CM</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Leave blank</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Enter Quality Improvement Organization (QIO) prior authorization number for procedures requiring QIO prior approval</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service (following will describe each item)</td>
<td></td>
</tr>
<tr>
<td>24a</td>
<td>Date for each procedure, service, or supply MMDDCCYY format</td>
<td></td>
</tr>
<tr>
<td>24b</td>
<td>Enter appropriate place of service code(s) for each item used or service performed</td>
<td></td>
</tr>
<tr>
<td>24c</td>
<td>Not required</td>
<td></td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>CMS 1500 Form Examples</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>24d</td>
<td>Enter procedures, services or supplies using HCPCS code(s). Modifiers if applicable</td>
<td><img src="D_PROCEDURES_SERVICES_OR_SUPPLIES.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>24e</td>
<td>Enter diagnosis code reference number to relate the date of service and procedures performed to the primary diagnosis</td>
<td><img src="DIAGNOSIS_POINTER.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>24f</td>
<td>Enter the charge for each listed service</td>
<td><img src="CHARGES.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>24g</td>
<td>Enter the number of days or units</td>
<td><img src="DAYS_UNITS.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>24h</td>
<td>Leave blank, not required</td>
<td></td>
</tr>
<tr>
<td>24i</td>
<td>Enter the ID qualifier 1c</td>
<td><img src="ID_QUAL.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>24j</td>
<td>Rendering provider’s NPI number</td>
<td><img src="RENDERING_PROVIDER_ID.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>25</td>
<td>Enter Federal Tax ID (Employer Identification Number or Social Security Number)</td>
<td><img src="FEDERAL_TAX_ID.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>26</td>
<td>Enter patient’s account number assigned by provider of service</td>
<td><img src="PATIENTS_ACCOUNT_NO.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>27</td>
<td>Check block to indicate if supplier accepts assignment of Medicare benefits</td>
<td><img src="ACCEPT_ASSIGNMENT.JPG" alt="Diagram" /></td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
<td>CMS 1500 Form Examples</td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>28</td>
<td>Enter total charges for services</td>
<td>28. TOTAL CHARGE $</td>
</tr>
<tr>
<td>29</td>
<td>Enter total amount patient paid on covered services only if applicable</td>
<td>29. AMOUNT PAID $</td>
</tr>
<tr>
<td>30</td>
<td>Leave blank, not required</td>
<td>30. BALANCE DUE $</td>
</tr>
<tr>
<td>31</td>
<td>Enter signature of provider of service and date the form was signed (MMDDYY or MMDDCCYY)</td>
<td>31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td>
</tr>
<tr>
<td>32</td>
<td>Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office</td>
<td>32. SERVICE FACILITY LOCATION INFORMATION</td>
</tr>
<tr>
<td>33</td>
<td>Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field</td>
<td>33. BILLING PROVIDER INFO &amp; PH #</td>
</tr>
</tbody>
</table>
C. CMS 1450 - UB 04

1. Overview
The UB-04 is a uniform institutional provider claim form and services many payers. The National Uniform Billing Committee (NUBC) maintains list of approved coding for the form.

The National Uniform Billing Committee (NUBC) is responsible for the design and printing of the UB-04 form. The NUBC is a voluntary, multidisciplinary committee that develops data elements for claims and claim-related transactions, and is composed of all major national provider and payer organizations.

BlueCare Plus follows the Center for Medicare & Medicaid Services (CMS) Guidelines for filing the National Provider Identifier (NPI) number.

The following UB04 guide is for educational purposes and does not ensure payment.

2. General Instructions

The UB-04 claim form is a hard-copy facility/institutional claim used by providers/suppliers to submit charges for services. The description below includes specifications for each form locator (field) of the UB-04 claim form. Additional instruction and information can be reviewed at the National Uniform Billing Committee Website.

3. CMS 1450 – UB-04 Quick Reference Guide

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>Description</th>
<th>UB 04 Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Billing provider name, address, city, state and zip (required)</td>
<td>1</td>
</tr>
<tr>
<td>Form Locator</td>
<td>Description</td>
<td>UB 04 Field</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>2</td>
<td>Billing provider’s designated Pay-to-Name, address, city, state and zip (not required)</td>
<td>2</td>
</tr>
<tr>
<td>3a</td>
<td>Patient Control Number (required)</td>
<td>3a PAT. CTRL. #</td>
</tr>
<tr>
<td>3b</td>
<td>Medical/Health Record Number assigned to patient’s medical/health record (situational)</td>
<td>3b MED. REC. #</td>
</tr>
<tr>
<td>4</td>
<td>Four-digit alphanumeric code gives three specific pieces of information after a leading zero (required). Code structure available in the Internet Only Manuals</td>
<td>4 TYPE OF BILL</td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax ID (required)</td>
<td>5 FED. TAX ID</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period (the from and through dates (required)) MMDDYY format.</td>
<td>6 STATEMENT COVERS PERIOD FROM THROUGH</td>
</tr>
<tr>
<td>Form Location</td>
<td>Description</td>
<td>UB 04 Field</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>Not used</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Patient's Name/ID (required)</td>
<td>8 Patient Name</td>
</tr>
<tr>
<td>9</td>
<td>Patient's address (required)</td>
<td>9 Patient Address</td>
</tr>
<tr>
<td>10</td>
<td>Patient's birth date in MMDDCCYY format (required)</td>
<td>10 Birth Date</td>
</tr>
<tr>
<td>11</td>
<td>Patient's sex, M or F (required)</td>
<td>11 SEX</td>
</tr>
<tr>
<td>12</td>
<td>Admission or start of care date (required)</td>
<td>12 Date 13 HR 14 Type 15 SRC</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour (not required)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Priority (type) of admission or visit (required) Codes also available from the NUBC via the NUBC's Official UB-04 Data Specifications Manual.</td>
<td>12 Date 13 HR 14 Type 15 SRC</td>
</tr>
<tr>
<td>15</td>
<td>Point of origin for admission or visit (required)</td>
<td></td>
</tr>
<tr>
<td>Form Locat or</td>
<td>Description</td>
<td>UB 04 Field</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td>16</td>
<td>Discharge hour (not required)</td>
<td>18 DHR</td>
</tr>
<tr>
<td>17</td>
<td>Patient discharge status (required)</td>
<td>17 STAT</td>
</tr>
<tr>
<td></td>
<td>This code indicates the patient’s discharge status as of the “Through” date of the billing period (FL 6)</td>
<td></td>
</tr>
<tr>
<td>18 - 28</td>
<td>Enter corresponding code to describe any condition or event that may apply to this billing period. (situational)</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Accident State (not used)</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Untitled (not used)</td>
<td></td>
</tr>
<tr>
<td>31-34</td>
<td>Occurrence Codes and Dates (situational)</td>
<td></td>
</tr>
<tr>
<td>35-36</td>
<td>Occurrence Span Code and Dates (situational)</td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Untitled (Not used)</td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Responsible Party (not required)</td>
<td></td>
</tr>
<tr>
<td>Form Locator</td>
<td>Description</td>
<td>UB 04 Field</td>
</tr>
<tr>
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<tr>
<td>39-41</td>
<td>Value Codes and Amounts (required)</td>
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<td>42</td>
<td>Revenue Code (required)</td>
<td>42 REV. CD.</td>
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<td>43</td>
<td>Revenue Description (not required)</td>
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<td>HCPCS/Rates/HIP PS Rate Codes (required)</td>
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<td>Service Date for services (required)</td>
<td>45 SERV. DATE</td>
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<td>46</td>
<td>Units of Service (required)</td>
<td>46 SERV. UNITS</td>
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<tr>
<td>47</td>
<td>Total Charges (Not applicable for electronic billers)</td>
<td>47 TOTAL CHARGES</td>
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<tr>
<td>48</td>
<td>Non-covered Charges Total non-covered charges pertaining to the related revenue code in FL 42 are</td>
<td>48 NON-COVERED CHARGES</td>
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<tr>
<th>50A-C</th>
<th>A (required) Enter the primary payer information</th>
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<td></td>
<td>B (situational) Enter secondary payer information if applicable</td>
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<td></td>
<td>C (situational) Enter tertiary payer information if applicable</td>
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<tr>
<th>51</th>
<th>A (required) Enter the primary payer plan identifier or the number assigned</th>
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<td>B (situational) Enter secondary payer plan identifier or the number assigned if applicable</td>
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<td></td>
<td>C (situational) Enter tertiary payer plan identifier or the number assigned if applicable</td>
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<td>52</td>
<td>Release of Information. A “Y” indicates the provider has on file a signed statement to release data to adjudicate the claim. (required)</td>
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<td>53</td>
<td>Assignment of Benefits Certification (not used)</td>
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<td>54</td>
<td>Prior Payments A, B &amp; C received amount to the provider towards this bill</td>
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<tr>
<td>55 A, B &amp; C</td>
<td>Estimated amount due from patient (not required)</td>
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<td>56</td>
<td>Billing provider National Provider ID (NPI) (required)</td>
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<tr>
<td>57</td>
<td>Other Provider ID (not used)</td>
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<tr>
<td>58 A, B &amp; C</td>
<td>Insured’s Name under whose name the insurance benefit is carried (required)</td>
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<tr>
<td>Location</td>
<td>Description</td>
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<tr>
<td>59 A, B &amp; C</td>
<td>Patient’s relationship to insured. Code for this field is available at <a href="http://www.nubc.org">www.nubc.org</a> (required)</td>
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<tr>
<td>60 A, B &amp; C</td>
<td>Insured’s unique ID number</td>
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<td>A – Required</td>
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<td></td>
<td>B - Situational</td>
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<tr>
<td></td>
<td>C – Situational</td>
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<tr>
<td>61 A, B &amp; C</td>
<td>Insurance group name through which insurance is provided</td>
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<td></td>
<td>A</td>
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<tr>
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<td>B</td>
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<td>C</td>
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<tr>
<td>62 A, B &amp; C</td>
<td>Insurance group number through which insurance is provided</td>
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<td>63</td>
<td>Treatment authorization code or referral number assigned by the payer (situational)</td>
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<td>64</td>
<td>Control number assigned to the original bill by the health plan for</td>
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<td>Form Locat or</td>
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<td>internal control (situational)</td>
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<td>65</td>
<td>If the provider is claiming payment and there is WC involvement or EGHP enter the name of employer that provides health care coverage</td>
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<td>66</td>
<td>Diagnosis and procedure codes (required).</td>
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<tr>
<td>67</td>
<td>Principal Diagnosis Code. These codes must be the full ICD diagnosis code, including all five digits where applicable. The principal diagnosis is condition chiefly responsible for an inpatient admission</td>
</tr>
<tr>
<td>67 A-67Q</td>
<td>Other Diagnosis Codes. Required when other condition(s) coexist or develop subsequently during the patient’s treatment (situational)</td>
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<td>69</td>
<td>Admitting diagnosis – Diagnosis is the condition identified by the provider at the time of the patient’s admission requiring hospitalization (required)</td>
</tr>
<tr>
<td>70 A-C</td>
<td>Patient’s reason for visit (situational)</td>
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<td>71</td>
<td>Prospective Payment System (PPS) code (not used)</td>
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<td>72</td>
<td>External Cause of Injury (ECI) codes (not used)</td>
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<td>74</td>
<td>Principal procedure code and date (situational)</td>
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<td>74A-E</td>
<td>Other procedure codes and dates (situational)</td>
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<td>76</td>
<td>Attending provider name and</td>
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<td>Description</td>
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<td>identifiers (including NPI)</td>
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<td>Operating provider name and identifiers (including NPI)</td>
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<td>78</td>
<td>Other provider name and identifiers (including NPI)</td>
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<td>79</td>
<td>Remarks For Renal Dialysis Facilities, the provider enters the first month of the 30-month period during which Medicare benefits are secondary to benefits payable under an EGHP. (See Occurrence Code 33.)</td>
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<tr>
<td>80</td>
<td>Code-Code field (situational)</td>
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(See Occurrence Code 33.)
4. **UB-04 Claim Form Sample**

**CMS 1450-UB04**

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**PAGE 180**
Final reimbursement determinations are based on several factors, including but not limited to, member eligibility on the date of service, Medical Appropriateness, code edits, applicable member copayments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and medical policy.

**D. Hospital Inpatient Acute Care**

The reimbursement mechanism for all inpatient hospital services will be Diagnosis Related Groups (DRG). BlueCare Plus’s DRG base rates and outlier per diems for each of the nine Combined Statistical Areas (CSA) as well as for Rural Referral Centers located in those CSAs are defined in Exhibit B-II of the BlueCare Plus Contract. Base rates and outlier per diems will be paid based on the Provider’s CSA.

The following guidelines are used in administering DRG reimbursement:

1. **DRG Assignment**

   BlueCare Plus has adopted the use of CMS’s grouper, the software package which assigns claims to a particular DRG, and the standard DRG definitions. Each discharge is assigned to only one DRG regardless of the number of services furnished or the number of days of care provided. DRG assignment will be made based upon the member’s principal diagnosis, additional diagnoses, and any procedures performed, as recorded in the medical record by the attending Physician.

   The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM and successor codes). The principal procedure and two additional procedures along with the patient's age, sex, and discharge status are reported to BlueCare Plus on the CMS-1450 with the hospital’s request for payment.

   Upon receipt, BlueCare Plus enters this information into its claims system and subjects the data to a series of automated edits called the Clinical Code Editor (CCE). These edits help identify cases that require further review before being classified into a DRG. Using the principal diagnosis (the condition which upon final study occasioned the admission), claims are assigned by the grouper into one of twenty-five (25) Major Diagnostic Categories (MDCs). Once the MDC is determined, claims are further differentiated based on age, sex, and the presence or absence of complicating conditions. Within most MDCs, cases are divided into surgical DRGs (based on a surgical hierarchy that orders individual procedures or groups of procedures by resource intensity) and medical DRGs. The medical DRGs are generally differentiated on the basis of principal diagnosis. Both medical and surgical DRGs may be further differentiated based on age, sex, and the presence or absence of complications or comorbidities.

   Under all circumstances, BlueCare Plus shall be the ultimate determiner of the DRG assignment. Hospitals that are dissatisfied with the DRG assignment a request for reconsideration may be submitted. The facility may submit additional information as part of its request. The BlueCare Plus Review Board will review the case, and if appropriate, change the DRG classification.
2. **Inpatient Short Stay Payments**
Inpatient stays for Observation will be subject to retroactive audit. Medical records that support the claim will be reviewed to determine if the payment is for services rendered. Where BlueCare Plus has paid for services beyond those actually provided, a recovery will be processed in accordance to audit recovery procedures. The claims will be adjusted in agreement with the allowed amount for Observation Services provided in an outpatient setting. To facilitate a more accurate accounting of the service, Institutions are encouraged to authorize Observation Services and bill these stays appropriately in an outpatient setting when applicable.

3. **Expired Patient Payments**
If a member expires after admission, full DRG will be allowed. The patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

4. **Transfer Payments**
If a member is transferred to another facility for the same or similar condition, a discharge as defined under the DRG payment system has not occurred. Cases that have been transferred are considered normal admissions for the receiving Institution and payment to there will be made in accordance with Provider Agreement. The facility transferring the member is paid based upon outlier per diems not to exceed the appropriate inlier payment. These claims are identified by the Discharge Status Codes filed on the claim as follows: 02 or 05. The facility from which the member is ultimately discharged receives the full DRG payment rate. When billing for a transfer payment, the appropriate discharge status must be indicated on the CMS-1450 claim in Form Locator 17, or its electronic claims equivalent. BlueCare Plus will authorize payment only if:

- The receiving facility initiated and followed the transfer review procedures of BlueCare Plus; and the services were medically necessary

5. **Readmissions**
A readmission is defined as an unplanned admission occurring within fourteen (14) days after a hospital discharge to the same or similar facility operating under the same contract for a complication of the original hospital stay or admission resulting from a modifiable cause. The following conditions are eligible for 14-day readmission review: CHF, COPD, and Class I surgeries. Claims for patients at either a DRG or Per Diem facility that are re-admitted under these circumstances are not eligible for multiple payments.

**Readmission Reimbursement**

Submitting a corrected bill or combining the services from the readmission with those of the initial admission will result in all services on the claim being disallowed. Also, billing with a “leave of
absence” revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim. Similarly, submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate, and services will be disallowed.

6. **Left against Medical Advice**
In the event that a member discharges himself or herself from the facility, against the advice of their doctor, payment will be made based upon outlier per diems not to exceed the appropriate inlier payment. Patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

7. **Unbundling of Services**
The BlueCare Plus rates are calculated with the assumption that professional and/or technical components of hospital-based practitioners and Certified Registered Nurse Anesthetists (CRNAs) will be separately billed on a CMS-1500 claim form. Bills for hospital-based practitioners and CRNA services must be submitted on a CMS-1500.

8. **Outpatient Services Treated as Inpatient Services**
Pre-admission Diagnostic Services performed on an outpatient basis by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility), within three days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period. Other Pre-admission Non-Diagnostic Services that are related to the member’s facility admission and performed by the admitting facility, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period. The term “day” refers to the calendar day(s) immediately preceding the date of admission or day following discharge. For example, if a member is admitted on Wednesday, services provided on Sunday, Monday and/or Tuesday are included in the inlier portion of the DRG payment, as opposed to 72 hours from the admission hour.

Exclusions: Ambulance Services, Chronic Maintenance Renal Dialysis Treatments, Home Health Services, Inpatient Services.

9. **Policy for Present on Admission (POA) Indicators**
This policy applies to claims billed on a CMS-1450/UB-04/ANSI-837I. Inpatient admissions to general acute care hospitals, requires the Present on Admission (POA) code on diagnoses (Form Locator 67) for discharges on or after Dec. 31, 2007, by using National Coding Standard guidelines. This may impact reimbursement. POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) Hospital providers bill for selected Hospital Acquired Conditions (HACs), Y0013_W14_P2
including some conditions on the National Quality Forum’s (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by The Centers for Medicare & Medicaid Services (CMS) POA Indicator Options:

**Present on Admission (POA) Indicator Options:**

- **Y** = Diagnosis was present at time of inpatient admission.
- **N** = Diagnosis was not present at time of inpatient admission.
- **U** = Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- **W** = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- **1** = Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.

The Present on Admission Indicator Reporting requirement applies only to Acute Inpatient Prospective Payment System (IPPS) hospitals. Facilities (as indicated by CMS) that are exempted from the POA Indicator requirements will not be required to submit the POA Indicator Option “1”.

**When filing electronic ANSI 837 inpatient facility claims,** providers should no longer enter Indicator Option “1” in the POA field when exempt from POA reporting. The POA field should be left blank for EDI format 5010 claims.

**When filing paper CMS-1450 (UB04) inpatient facility claims,** providers should enter a “1” in the POA field when exempt from POA reporting.

When any other POA Indicator Options apply, they should be reported in the POA field on both electronic and paper claims.

**Claims will reject if:**

- POA “1” is submitted on an electronic ANSI 837 inpatient claim; or
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; or
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the Centers for Medicare & Medicaid (CMS) website at [http://www.cms.gov/HospitalAcqCond/](http://www.cms.gov/HospitalAcqCond/).

10. **Emergency/Non-emergency**
National Uniform Billing Committee (NUBC) guidelines limit the emergency room revenue codes that can be submitted on the same claim with each other. For example, Revenue code 0450 should not be submitted with any of the other emergency room revenue codes. Not following these guidelines may result in rejection of claim. NUBC information may be found at [http://www.nubc.org/index.html](http://www.nubc.org/index.html).
Emergency Room Services:
Emergency Room services (revenue code 0450) do not require an authorization. Reimbursement will be based upon the current fee schedule. Ancillary charges should be filed with the appropriate CPT® or HCPCS code.

Emergency Room Services filed with Observation:
Emergency Room services (revenue code 0450) filed with Observation charges (revenue code 0762) are considered part of the Observation room charge and are not reimbursed separately. Ancillary charges should be filed with the appropriate CPT® or HCPCS code.

Emergency Room Services filed with Outpatient Surgery:
Emergency Room services (revenue code 0450) filed with Outpatient Surgery will be reimbursed in addition to the outpatient surgical reimbursement. Ancillary services are considered all-inclusive in the Outpatient Surgical Fee (OSF) reimbursement.

Emergency Room Services filed with Observation and Outpatient Surgery:
Emergency Room services (revenue code 0450) and Observation services filed with Outpatient Surgery services are considered all-inclusive in the Outpatient Surgery reimbursement and are not reimbursed separately. Ancillary services are considered all-inclusive in the OSF reimbursement.

Emergency Room Services filed on an Inpatient CMS-1450 claim form (Inpatient setting):
Emergency Room services filed on a CMS-1450 claim are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

Observation filed with Emergency Room Services:
Observation and all services not considered incidental* to the emergency room visit are reimbursed fee-for-service. Charges billed for use of the emergency room, Revenue Code 0450, are considered part of the observation room charge and are not reimbursed separately.

Observation filed with Outpatient Surgery:
Observation charges (revenue code 0762) billed up to 6 hours along with an outpatient surgery is considered all-inclusive in the surgery reimbursement and is not reimbursed separately. Reimbursement for Observation will be allowed in addition to the surgery when the claim is filed with an Observation room charge. For multiple surgeries filed on the same claim form with Observation, the highest level code is reimbursed at 100% of the Outpatient surgery fee schedule and each additional surgical code is reimbursed at 50% of the Outpatient surgery fee schedule. The highest level code is not determined by the greatest total charge but by the highest allowed.

Observation filed on an Inpatient claim (inpatient setting):
Observation services filed on a CMS-1450 claim form are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

*Incidental services include but are not limited to those services billed under Revenue Codes:
11. Skilled Nursing Facility (SNF)

In order for SNF services to be covered under BlueCare Plus, care and treatment must be medically necessary and appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel. SNFs are required to follow CMS guidelines regarding delivery of the Notice of Medicare Non-coverage (NOMNC). (See details of Notice of Medicare Non-Coverage (NOMNC) in this Manual.) To facilitate an advance determination or prior authorization request please use the BlueCross BlueShield of Tennessee Skilled Nursing Fax form located online at http://bluecareplus.bcbs.com/docs/providers/UM_Skilled_Nursing_Facility_Request_Fax.pdf or fax to 1-866-325-6698.

BlueCare Plus has dedicated RN Care Coordinators available to assist you with necessary services for your BlueCare Plus patients. Our Health Management team can be contacted at 1-800-924-7141.

Basic information needed for processing an advance determination request:

- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number and/or NPI, Medicare number, address and telephone number;
- Admission date; and
- Caller’s name.

Clinical information required for review:

- Admitting diagnosis, symptoms, and treatment plan;
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination;
- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A practitioner’s order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice);
• Expectation for significant reportable improvement within a predictable amount of time; and
• Discharge Plans.

12. **Home Health Services**

Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the member's health or to facilitate treatment of the member's illness or injury. In order for the services to be covered under BlueCare Plus, the member must have a medical condition that makes him/her unable to perform personal care and meet medical necessity and medical appropriateness criteria. Documentation must support the member’s limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in member's care.

Basic information needed for processing an advance determination request:

- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller's name.

Clinical information/documentation required for review.

All Home Health services for HMO D-SNP Plus should be billed on the CMS-1450 using Type of Bill (TOB) 32X. When submitting ANSI-837 electronic claims, the Institutional format must be used. Home Health services should be billed using the following Revenue Codes and billing units:

Home Health services not billed with the indicated revenue codes are rejected or denied. A procedure code may be billed to further identify the service provided, but is not required. To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated. Supplies on the BlueCross BlueShield of Tennessee Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) manual. Supplies not billed with the indicated Revenue Codes and HCPCS codes will be rejected or denied. Reimbursement for supplies not indicated on the BlueCross BlueShield of Tennessee Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health service and will not be reimbursed separately. Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit are the responsibility of the Home Health Agency.
Supplies not used in conjunction with a Home Health visit are not billable by the Home Health Agency provider.

13. **Retrospective Review (post pay)**
BlueCare Plus will conduct Retrospective Review to provide a decision based on benefit eligibility, exclusion(s), and Appropriateness and Medical Necessity of services. References used to determine Appropriateness and Medical Necessity include Title 18 of the Social Security Act, Title 42 Code of Federal Regulations Parts 422 and 476, National Coverage Determinations, Local Coverage Determinations, coverage in CMS’ Interpretive Manuals (Claims Processing Manual, Benefit Policy Manual, Program Integrity Manual, Quality Improvement Organization Manual, and Medical Managed Care Manual), Milliman Care Guidelines, BlueCross BlueShield of Tennessee adopted guidelines, the BCBST claims payment system, DMEMAC associated PSC local coverage determinations and other major payer policy and peer reviewed literature.

14. **Comprehensive Outpatient Rehabilitation Facility (CORF)/Outpatient Rehabilitation Facility (ORF) and Outpatient Physical Therapy**
Supplies furnished by CORFs/ORFs and OPTs are considered part of the practice expense. Under the Medicare Physician Fee Schedule (MPFS) these expenses are already taken into account in the practice expense relative values. Therefore, CORFs/OPTs should not bill for the supplies they furnish except for the splint and cast, level II HCPCS Q codes associated with the level I HCPCS in the 29000 series.

Financial limitations for therapy services were initiated by the Balanced Budget Act (BBA) of 1997. Medicare limits the amount paid for medically-necessary outpatient therapy services in one calendar year. These limits are called “therapy caps”. The limitation is based on therapy services the member receives, not the type of practitioner who provides the service. Physical therapists, speech-language pathologists, occupational therapists as well as physicians and certain non-physician practitioners could render a therapy service.

The therapy cap applies to all Part B outpatient therapy settings and providers include:
- Private practices,
- Skilled nursing facilities,
- Home health agencies,
- Outpatient rehabilitation facilities and
- Comprehensive outpatient rehabilitation facilities
- Hospital outpatient departments

The exception process to the therapy cap requires any services above the therapy cap amount must be reasonable and medically necessary and documented in the patient’s medical record. The KX modifier on the claim indicates that the requirements have been met for the exception to the therapy cap. Claims that exceed the cap and do not include the KX modifier will be denied.
The annual limit is announced in the final rule of the Medicare Physician Fee Schedule, release on or about November 1 of each year. It is also available on The Centers for Medicare and Medicaid (CMS) Website at [www.cms.gov/therapyservices](http://www.cms.gov/therapyservices).

a. **Billing Overview**

   **Applicable Types of Bill for CORFs and ORFs**

   - 074X  Clinic Outpatient Physical Therapy
   - 075X  Clinic Comprehensive Outpatient Rehabilitation Facility

   **Applicable Revenue Codes**

   - 0420 - Physical Therapy Services
   - 0430 - Occupational Therapy Services
   - 0440 – Speech-language pathology services

   **Modifiers**

   - GN
   - GO
   - GP

   **Line Item Date of Service**

   Providers are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFs are required to report their full range of CORF services by line item date of service.

   **Non-covered Charge Reporting**

   Institutional outpatient therapy claims may report non-covered charges when appropriate. The non-covered charges are not counted toward the financial limitation. Modifiers associated with non-covered charges can be used on claim lines for therapy services, in addition to GN, GO and GP.

**Resources**

For additional information visit The Centers for Medicare & Medicaid Services (CMS) Website at [www.cms.gov/Medicare/Billing/TherapyServices/index.html](http://www.cms.gov/Medicare/Billing/TherapyServices/index.html).

**Outpatient Rehabilitation**

Freestanding Inpatient Rehabilitation facilities, Freestanding Outpatient Rehabilitation facilities, and Skilled Nursing facilities should bill BlueCare Plus for services rendered on a CMS-1450/ANSI-837 Institutional Transaction claim form. In general the UB National Uniform Billing Guide should be followed.

Only those HCPCS and CPT® codes related to Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, and/or Wound Care* Services should be billed in conjunction with BlueCare Plus Rehabilitation Fee Schedules. Services billed outside of the agreement are subject to recovery.
Outpatient Rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:

<table>
<thead>
<tr>
<th>Type of Bill (TOB)</th>
<th>Type of Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>13X</td>
<td>Freestanding Inpatient Rehabilitation Facilities providing outpatient therapy services</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities providing outpatient therapy services</td>
</tr>
<tr>
<td>74X</td>
<td>Clinic Outpatient Physical Therapy</td>
</tr>
<tr>
<td>75X</td>
<td>Clinic Comprehensive Outpatient Rehabilitation Therapy</td>
</tr>
</tbody>
</table>

**Revenue Codes**

Providers enter the appropriate revenue codes from the following list to identify specific accommodation and/or ancillary charges. It must enter the appropriate numeric revenue code on the adjacent line in FL 42 to explain each charge in FL 47. Additionally, there is no fixed “Total” line in the charge area.

Codes are available from the NUBC (www.nubc.org) via the NUBC’s Official UB-04 Data Specifications Manual.

15. **National Drug Code (NDC) Billing**

The NDC is a code set that identifies the vendor (manufacturer), product and package size of all drugs and biologics recognized by the FDA. It is maintained and distributed by HHS, in collaboration with drug manufacturers. To access the complete NDC code set, see the FDA U.S. Food and Drug Administration website for the latest information at: www.fda.gov/Drugs/InformationOnDrugs/ucm142438.htm

The requirements for the collection of NDCs became effective January 1, 2007. When required to submit NDC drug number and quantity information for Medicaid rebates on the CMS-1500 paper claim be aware of the following:

- Submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13.
- The NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC code (e.g. N49999999999).
- Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units),
- F2 (international units), GR (gram) or ML (milliliter). There are six positions available for quantity. If the quantity is less than six positions, the entry should be left justified with spaces filling the remaining positions.

### ANSI 837 Loop

<table>
<thead>
<tr>
<th>Field Description</th>
<th>837P Segment</th>
<th>837I Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Name description information</td>
<td>SV101-7</td>
<td>SV202-7</td>
</tr>
<tr>
<td>Drug Ingredient Billed Amount</td>
<td>SV102</td>
<td>SV203</td>
</tr>
<tr>
<td>HCPCS Unit of Measure</td>
<td>SV103</td>
<td>SV204</td>
</tr>
<tr>
<td>HCPCS Quantity</td>
<td>SV104</td>
<td>SV205</td>
</tr>
<tr>
<td>NDC Qualifier of N4</td>
<td>LIN02</td>
<td>LIN02</td>
</tr>
<tr>
<td>NDC code (11 digits)</td>
<td>LIN03</td>
<td>LIN03</td>
</tr>
<tr>
<td>NDC Quantity</td>
<td>CTP04</td>
<td>CTP04</td>
</tr>
<tr>
<td>NDC Unit of Measure (F2, GR, ME, ML, UN)</td>
<td>CTP05-1</td>
<td>CTP05-1</td>
</tr>
</tbody>
</table>

### Exceptions to NDC Requirement for Provider-Administered Medical and Facility Drug Claims:
- Vaccines
- Inpatient administered drugs

NDC requirements must also be fulfilled by facilities filing outpatient CMS UB-04 form or submitted electronically in the ANSI-837I version format with the same exceptions listed above. NDC information is not required on inpatient claims. When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/ CPT® code. Any missing element may result in the claim being returned unprocessed.
XII. Remittance Advice

BlueCare Plus issues notices called Remittance Advices (RA) to communicate claims processing decisions such as payments and adjustments. The RA provides justification for the payment, as well as input to your accounting system/accounts receivable and general ledger applications. The codes on the RA identify any additional action you may need to take; for example, an RA code may indicate you may need to resubmit the claim with corrected information.

The RA provides detailed payment information about a health care claim(s) and describes the payment; it also features valid codes and specific values that make up the claim payment.

Once you receive the RA you may:

- Post the decision and payment information automatically when a compatible provider accounts receivable software application is being used
- Identify reasons for any adjustments, denials or payment reductions
- Note when the Electronic Funds Transfer (EFT) payment issued with the RA is scheduled for deposit

The Remittance Advice displays the following columns.

<table>
<thead>
<tr>
<th>Patient Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Last Name</strong></td>
</tr>
<tr>
<td><strong>First Name</strong></td>
</tr>
<tr>
<td><strong>Patient Account</strong></td>
</tr>
<tr>
<td><strong>Member ID</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Number</strong></td>
</tr>
<tr>
<td><strong>Recv’d DT</strong></td>
</tr>
<tr>
<td><strong>Serv Prov</strong></td>
</tr>
<tr>
<td><strong>Date of Service</strong></td>
</tr>
<tr>
<td><strong>From/Thru</strong></td>
</tr>
<tr>
<td><strong>Procedure/Modifier</strong></td>
</tr>
<tr>
<td><strong>Total Charges</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y0013_W14_P2</td>
</tr>
<tr>
<td><strong>Patient Non-Covered</strong></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Note</strong></td>
</tr>
<tr>
<td><strong>Contract Write Off</strong></td>
</tr>
<tr>
<td><strong>Note</strong></td>
</tr>
<tr>
<td><strong>Patient DED/COPAY</strong></td>
</tr>
<tr>
<td><strong>Patient COINS</strong></td>
</tr>
<tr>
<td><strong>Other Insurance</strong></td>
</tr>
<tr>
<td><strong>Claim Paid</strong></td>
</tr>
<tr>
<td><strong>Interest Paid</strong></td>
</tr>
<tr>
<td><strong>Patient Owes</strong></td>
</tr>
</tbody>
</table>

Included is an example of the BlueCare Plus Remittance Advice
The patient deductible copay of coinsurance amounts should not be billed to the member. BlueCare Plus forwards these claims to the Division of TennCare for processing of member cost sharing.

BlueCare Plus currently receives electronic claims, which include; initial claims submission and corrected bills.

To discuss issues specific to your organization, please contact eBusiness Technical Support at (423) 535-5717, or (800) 924-7141, Monday – Thursday 8 a.m. to 5:15 p.m. (ET) or Friday 9 a.m. to 5:15 p.m. (ET). More information is also available at the following link: http://www.bcbst.com/providers/ecomm/, or you can contact us via email at eBusiness_Service@bcbst.com.

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data or revalidating enrollment, must use Electronic Funds Transfer (EFT) to receive payments. For EFT information,
A. Risk Adjustment

Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage (MA) plans, such as BlueCare Plus, for the health status and demographic characteristics of their enrollees.

CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes and successor codes) and encounter data submitted by MA plans to establish risk scores. The primary source of encounter data or ICD-9 codes and successor codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.

CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and successor codes with supporting documentation in their medical record. The physician’s role in risk adjustment includes:

- Accurately reporting ICD-9-CM diagnosis codes and successor codes to the highest level of specificity (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent and legible.
- Documentation of all conditions treated or monitored at the time of the face-to-face visit in support of the reported diagnoses codes.
- Use of standard abbreviations.
- Notifying the Medicare Advantage plan of any erroneous data submitted and following the appropriate procedures to correct erroneous data (see Section VI. Billing and Reimbursement in this Manual for instructions on submitting a Corrected Bill).
- Submitting claims data in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions).

Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM and successor codes coding specificity.

1. Risk Adjustment Data Validation (RADV) Audits conducted by CMS

Annually, CMS selects (both random and targeted) Medicare Advantage (MA) Organizations for a data validation audit. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA or Medicare Advantage organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the data collection period, and ensuring the provider’s signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate
documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

2. **Risk Adjustment Impact for Physicians and Members**

It is important to keep in mind that the risk adjustment process also benefits the provider and the patient. Increased coding accuracy helps BlueCross BlueShield of Tennessee identify patients who may benefit from disease and medical management programs. More accurate health status information assists in matching health care needs with the appropriate level of care. Risk adjustment helps meet the provider’s CMS responsibilities regarding reporting ICD-9-CM codes and successor codes, including:

- Secondary diagnoses, to the highest level of specificity
- Maintaining accurate and complete medical records (ICD-9-CM codes and successor codes must be submitted with proper documentation)
- Reporting claims and encounter data in a timely manner

With provider assistance in providing accurate and timely coding for risk adjustment, Unnecessary and costly administrative revisions can be avoided, and provide patients and BCBST’s members with superior customer service.

3. **Medical Record Documentation Tips for meeting CMS requirements for submission of encounter data and RADV audits:**

Federal regulations require Medicare and its agents (BCBST) to review and validate medical records in order to avoid underpayments or overpayments. It is important for the physician’s office to code each encounter in its entirety; the claim should report the ICD-9-CM code and successor codes of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.

Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses are reported.

**Medical Record Documentation**

- Documentation should be clear, concise, consistent, complete and legible.
- Documentation of coexisting conditions at least annually.
- Use standard abbreviations.
- Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code and successor codes on the date of service, and are signed and dated by the physician or physician extender).
- Identify patient and date on each page of the record.
Authenticate the record with signature and credentials.

Progress Note Requirements:
- Progress notes must contain patient name and DOS on each page.
- If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages are not numbered, then the provider must sign each page of the progress note.
- Progress notes should follow the standard S.O.A.P. format.

Provider Signature Requirements on Progress Note:
- All progress notes must be signed by the provider rendering services.
- Provider credentials must either be pre-printed on the progress notes as a stationary or the provider must sign all progress notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the provider.
- Provider signature must be legible, i.e., “John Smith Doe, M.D.” or “JSD, MD”. If a Provider’s signature is illegible, a signature log must be completed.
- Stamped signatures are no longer acceptable for provider documents as of April 28, 2008, as stated by CMS (Medicare Program Integrity Manual, Transmittal 248, Change Request 5971.5550). For risk adjustment purposes (Part C), signature stamps will no longer be acceptable on medical records with dates of service on or after January 1, 2009.
- Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line: “Electronically signed”, “Authenticated by”, “Signed by”, “Validated by”, “Approved by”, or “Sealed by”. The signed EMR record must be closed to all changes.
- Sign off on medical records should be completed timely.

Diagnosis Documentation Requirements on Progress Note:
- Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions, i.e., DM w/Neuropathy – meds adjusted, CHF-compensated COPD – test ordered, HTN – uncontrolled, Hyperlipidemia – stable on meds. CMS considers diagnoses listed on the progress note without an evaluation or assessment as a “problem list”, which is not acceptable for risk adjustment submission.
- Use the words “history of” cancer, stroke, etc., to indicate the condition is no longer a current health concern. Avoid using “history of” for conditions the member still has or for which they are being treated. For example, indicating a history of diabetes is not correct. While the member has diabetes in his history, it is still a current condition. Likewise, a patient may have CHF exacerbation in his past but CHF stable is the current condition. The coding for CHF is the same for both instances – 428.0.
- Each progress note must be able to “stand alone”. Do not refer to diagnoses from a preceding progress note, problem list, etc.
- Avoid documentation of diagnosis as probable, suspected, questionable, rule out, or working, rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
4. **Releasing Medical Records**

BlueCare Plus has the right to request medical records without charge to ensure appropriate coding and/or identify additional diagnosis for risk adjustment data submission to CMS. Providers may receive requests from the Risk adjustment Department for medical records with specific dates of service for review. Medical records can be mailed, faxed or collected on site from the provider’s office.

Mail to:

**ATTN:** BlueCare Plus HMO DSNP - Risk Adjustment  
BlueCare Plus  
1 Cameron Hill Circle, Ste 0037  
Chattanooga, TN 37402-9923

Fax to: 1-800-495-1944  
(423) 535-3609

5. **Confidentiality and General Consent**

Confidentiality of patient information is important to BlueCross BlueShield of Tennessee. Any information disclosed by you in response to medical record requests for risk adjustment will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the “general consent” of the patient. A general consent form should be an integral part of your patient’s medical records file.

6. **Risk Adjustment Data**

Providers are encouraged to code all members’ diagnoses to the highest level of specificity. All encounters for dually eligible members must be submitted to BlueCare Plus.

A sample copy of the Risk Adjustment Medical Record Request letter follows:
Date

Provider Name/Credentials
Address Member Name:
City, State Zip DOB:

Member ID Number:
Member Name:
DOB:
Reference #
Provider #
Doc Class: MedRec
Cost Center # 7570

Dear Provider:

To ensure integrity of risk adjustment data submitted to the Centers for Medicare & Medicaid Services (CMS), and, as part of our ongoing Risk Adjustment Program, we have reviewed claims history for the above-referenced member and determined that additional information is needed. Our request for medical records is conducted in accordance with CMS guidelines and is based upon the terms and conditions of your Medicare Advantage Provider Agreement (Section C.7) and/or the Model Terms and Conditions of Payment (Section 6). Please submit a copy of this letter along with all pertinent medical records for dates of service _____________, including any narrative history and physical results, all notes written or dictated, and a copy of the Subjective Objective Assessment Plan (SOAP). CMS requires that medical record documentation contain the dates of service, patient’s name and a legible physician’s signature with credentials. Please mail or fax the requested medical records within 21 business days to:

ATTN: Risk Adjustment Department
BlueCross BlueShield of Tennessee
BlueCare Plus Operations
1 Cameron Hill Circle, Ste 0037
Chattanooga, TN 37402-9923
Fax: 1-800-495-1944
(423) 535-3609

Confidentiality of “individually identifiable patient information” is important to BlueCross BlueShield of Tennessee, Inc. and is required by law. Any information disclosed by you in response to this request will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the “general consent” of the patient. A general consent form should be an integral part of your patient’s medical records file. Thank you in advance for your cooperation. If you should have any questions, please contact us at 1-800-515-2121, ext. 3589.

Sincerely,

Y0013_W14_P2
Name
Medicare Advantage Risk Adjustment Department
BlueCross BlueShield of Tennessee
For additional information regarding risk adjustment, visit:

Provider Quick Reference Guide – Risk Adjustment:

Guide to Documentation – Risk Adjustment
XIII. Quality Improvement Program

The BlueCare Plus Quality Improvement Program provides the framework for the evaluation of the delivery of healthcare services and other services provided to members. The QI Program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of care and service provided to BlueCare Plus members. The QI Program is a three-tiered system of performance improvement that meets the following criteria:

Tier one consists of data for quality and health outcomes that are collected and analyzed to allow beneficiaries to compare and select from the available health coverage options. The data includes selected HEDIS® measures, STARs measures, Satisfaction measures, and other structure and process measures. Each year, CMS provides guidance on HEDIS and STARs measures that health plans are required to report on for the contract year.

Tier two is made up of collection, analysis, and reporting data that measure the performance SNP Model Of Care (MOC).

Tier three consists of monitoring of the implementation of care management through the collection and analysis of selected data that measure the effectiveness of SNP MOCs.

BlueCare Plus must provide for the collection, analysis, and reporting of data that measure health outcomes and indices of quality pertaining to the dually eligible members special needs population.

A. HEDIS Measures

The Medicare Advantage (MA) / Part D Contract and Enrollment Data section serves as a centralized repository for publicly available data on contracts and plans, enrollment numbers, service area data, and contact information for MA, Prescription Drug Plan (PDP), cost, Program of All-inclusive Care for the Elderly (PACE), and demonstration organizations.

HEDIS® is a product of NCQA. MAOs meeting CMS’s minimum enrollment requirements must submit audited summary-level HEDIS® data to NCQA. Contracts with 1,000 or more members enrolled as reported in the July Monthly Enrollment by Contract Report (which can be found at http://www.cms.hhs.gov/MCRAAdvPartDEnrolData/MEC/list.asp#TopOfPage).

BlueCare Plus must collect and submit HEDIS® data to CMS. Closed cost contracts are required to report HEDIS® as long as they meet the enrollment threshold in the reporting year. Patient-level data must be reported to the CMS designated data contractor. Information about HEDIS® reporting
requirements is posted on the HPMS webpage. During the contract year, if an HPMS contract status is listed as a consolidation, a merger, or a novation, the surviving contract must report HEDIS® data for all members of the contracts involved. If a contract status is listed as a conversion in the data year, the contract must report if the new organization type is required to report.

CMS collects audited data from all benefit packages designated as SNPs and contracts with ESRD Demonstration Plans that had 30 or more members enrolled as reported in the SNP Comprehensive Report (which can be found at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage).

The data collection methodologies for HEDIS® are either the administrative or the hybrid types. The administrative method is from transactional data for the eligible populations and the hybrid method is from medical record or electronic medical record and transactional data for the sample.

B. Consumer Assessment of Health Providers and Systems (CAHPS)

The CAHPS survey is a CMS driven member survey evaluating multiple areas that impact members including provider encounters. The CAHPS survey collects information on the quality of health services provided by insurance plans. Consumer evaluations of health care and prescription drug services, such as those collected through the CAHPS surveys, measure important aspects of a patient’s experience that cannot be assessed by other means.

CMS offers a listing of reports from the annual CAHPS surveys on its website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS.

The CAHPS Module divides the following sections based on the various CAHPS surveys CMS sponsors:

- Fee for Service CAHPS (FFS CAHPS)
- Hospital CAHPS (H CAHPS)
- In Center Hemodialysis CAHPS (ICH CAHPS)
- Medicare Advantage CAHPS (MA CAHPS)
- Nursing Home CAHPS (NH CAHPS)

C. STARS

CMS uses a five-star quality rating system to measure Medicare beneficiaries’ experience with their health plans and the health care system including providers in the healthcare system. The rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS) and prescription drug plans (PDP).
The program is a key component in financing health care benefits for MA plan members. In addition, the ratings are posted on the CMS consumer website, https://www.medicare.gov, to provide information for beneficiaries choosing an MA plan in their area.

Stars will help promote quality improvement and performance measures. These ratings strengthen beneficiary protections and allow CMS to distinguish stronger health plans and remove consistently poor performers.

**How are Star Ratings Derived?**

Health plans are rated based on measures in five categories:
- Members’ compliance with preventive care and screening recommendations
- Chronic condition management
- Plan responsiveness, access to care and overall quality
- Customer service complaints and appeals
- Clarity and accuracy of prescription drug information and pricing

**Benefits to Providers**
- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

**Benefits to Members**
- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer satisfaction
- Greater focus on preventive services for peace of mind, early detection and health care
- Matches their individual needs

BlueCare Plus is strongly committed to providing high-quality Medicare health coverage that meets or exceeds all CMS quality benchmarks. The structure and operations of the CMS Stars rating system will ensure that resources are used to protect, or in some cases, to increase benefits and keep member premiums low. BlueCare Plus encourages members to become engaged in their preventive and chronic-care management through outreach and screening opportunities. Providers are an important partner in these efforts.

**TIPS FOR PROVIDERS**
- Encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify patients that appear to be non-adherent at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Submit clinical data such as lab results to BlueCare Plus and/or BlueCare Plus Quality Care Rewards portal.
• Communicate clearly and thoroughly; ask:
  o What questions do you have?
  o Have you seen a specialist or been an inpatient in the hospital since your last visit?
  o Have you been in the emergency room since your last visit?
  o May we review your current medications?
• Understand each measure you as a provider impact.
• Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to identify opportunities for you or your office to have an impact: 

CMS has created the Health & Drug Plan Quality and Performance Ratings 2018 Part C & Part D Technical Notes, to review this document in its entirety follow this link.

This document describes the methodology for creating the Part C and D Plan Ratings displayed in the Medicare Plan Finder (MPF) tool on http://www.medicare.gov/. These ratings are displayed in the Health Plan Management System (HPMS) for contracts and sponsors. In the HPMS Quality and Performance section, the Part C data can be found in the Part C Performance Metrics module in the Part C Report Card Master Table section. The Part D data are located in the Part D Performance Metrics and Report module in the Part D Report Card Master Table section. All of the health/drug plan quality and performance measure data described in the document are reported at the contract level. Table 1 lists the contract year 2018 organization types and whether they are included in the Part C and/or Part D Plan Ratings.

The Plan Ratings strategy is consistent with CMS’ Three-Part Aim (better care, healthier people/healthier communities, and lower costs through improvements) with measures spanning the following five broad categories:

• Outcomes: Outcome measures focus on improvements to a beneficiary’s health as a result of the care that is provided.
• Intermediate outcomes: Intermediate outcome measures help move closer to true outcome measures. Controlling Blood Pressure is an example of an intermediate outcome measure where the related outcome of interest would be better health status for members with hypertension.
• Patient experience: Patient experience measures represent members’ perspectives about the care they have received.
• Access: Access measures reflect issues that may create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
• Process: Process measures capture the method by which health care is provided.

D. Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the first outcomes measure used in Medicare managed care and the largest survey effort ever undertaken by the Centers for Medicare & Medicaid Services (CMS). The goal of the Medicare HOS program is to gather valid and reliable health status
data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. Managed care plans with Medicare Advantage (MA) contracts must participate. CMS has provided a website for review located at [www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/hos.html](http://www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/hos.html) This website is designed to provide current information on the progress of the HOS program, as well as house the full spectrum of Medicare HOS related data and reports.

The Veterans RAND 12-Item Health Survey (VR-12), supplemented with additional case-mix adjustment variables and four HEDIS® Effectiveness of Care measures, will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS® functional status measure, HOS. This measure is the first "outcomes" measure for the Medicare managed care population. Because it measures outcomes rather than the process of care, the results are primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that BlueCare Plus currently uses for clinical quality improvement.
# XIV. Provider Manual Change Document

## Provider Manual Update

Update 20181001

<table>
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<td>20181001.01</td>
<td>Entire Manual</td>
<td>Formatting updates to add consistency to text font, text size, and content alignment.</td>
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<td>Changing “BlueCare Plus HMO D-SNP” to “BlueCare Plus”</td>
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<td>Correcting links for <a href="http://www.bcbst.com">www.bcbst.com</a> and <a href="http://www.bluecareplus.bcbst.com">www.bluecareplus.bcbst.com</a>.</td>
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<td>Updated Contact Information Chart</td>
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<td>Language changes to reflect online fraud reporting process</td>
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<td>Updating link for reporting suspected TennCare recipient fraud and/or abuse</td>
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<td>27 to 53</td>
<td>Addition of new language to Chapter II. Section E. Provider Networks to bring the content into alignment with the other BCBST Provider Manuals.</td>
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<td>Addition of new language to Chapter II. Section F. Provider Credentialing to bring the content into alignment with the other BCBST Provider Manuals.</td>
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<td>Correcting TennCare links for provider information, member information, and LTSS information.</td>
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<td>Updated BlueCare Plus Summary of Benefits Chart</td>
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<td>Significant revisions to Chapter IV. General Guidelines for Benefits impacting every existing section with additions of new sections.</td>
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<td>20181001.14</td>
<td>128 to 129</td>
<td>Significant revisions to Chapter V. Non-Covered Benefits impacting every existing section with removal of sections.</td>
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<td>20181001.15</td>
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<td>Significant revisions to Chapter VIII. Model of Care (MOC) D-SNP</td>
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<td>Revisions to Chapter IX. Section C. Discharge Planning/Transition of Care</td>
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<td>Adding Clinical Practice Guidelines</td>
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Update 20170313

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<td>20170313.2</td>
<td>03</td>
<td>Adding Non-Discrimination to Table of Contents</td>
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<td>Add section for Non-Discrimination</td>
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<td>53</td>
<td>Changing sentence to read: A physician may request To obtain an expedited determination, by calling us at 1-866-789-6314</td>
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<td>Adding Provider Dispute Procedure</td>
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<td>Adding Re-Admission Reimbursement and Quality Program Information</td>
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<td>20170313.7</td>
<td>02</td>
<td>Updating page numbers to Table of Contents to reflect additional information</td>
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Update 20150624

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<td>Removed “CMS1450using”</td>
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<td>Changed TOB 33X to 32X as BlueCare Plus does not follow the same Medicare reimbursement methodology as Original Medicare. CMS Internet Only Manual, Publication 100-04, Chapter 10, Section 40.2 “HH PPS applies only to Medicare fee-for-service”.</td>
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<td>Removed “T” from PCP</td>
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<td>Changed “meetings” to “reviews”</td>
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<td>Changed “packet” to “document”</td>
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<td>Added “of” to “an” for and</td>
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<td>Added additional paragraph for the BlueCare Plus ICT process</td>
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<td>Correct from member to member’s</td>
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<td>Corrected spelling from <em>wither</em> to <em>whether</em></td>
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<td>96</td>
<td>Added <em>electronically or by fax</em> to method of distributing ICT document</td>
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<td>20150624.12</td>
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<td>Remove &quot;<em>or</em>&quot; DUPLICATE</td>
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Update 20141110
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<td>20141110.1</td>
<td>166</td>
<td>Addition of National Drug Code Billing instructions including billing information regarding the filing a claim with an NDC number</td>
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<td>20141110.2</td>
<td>118</td>
<td>Addition of Observation Notifications information. Adding observation notification requirements and procedure.</td>
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<tr>
<td>20141110.3</td>
<td>166</td>
<td>Correcting “provider” to “providing”</td>
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<td>20141110.4</td>
<td>170</td>
<td>Changing CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes) and encounter data submitted by MA plans to establish risk scores to the following; CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes and successor codes) and encounter data submitted by MA plans to establish risk scores</td>
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<tr>
<td>20141110.5</td>
<td>170</td>
<td>The primary source of encounter data or ICD-9 codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review. The primary source of encounter data or ICD-9 codes and successor codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.</td>
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<td>20141110.6</td>
<td>170</td>
<td>CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and with supporting documentation in their medical record. CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and successor codes with supporting documentation in their medical record.</td>
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<tr>
<td>20141110.7</td>
<td>170</td>
<td>• Accurately reporting ICD-9-CM diagnosis codes to the highest level of specificity (critical as this determines disease severity). • Accurately reporting ICD-9-CM diagnosis codes and successor codes to the highest level of specificity (critical as this determines disease severity).</td>
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<tr>
<td>20141110.8</td>
<td>171</td>
<td>Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM coding specificity. Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM and successor codes coding specificity.</td>
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<td>20141110.9</td>
<td>171</td>
<td>Risk adjustment helps meet the provider’s CMS responsibilities regarding reporting ICD-9-CM codes, including: Risk adjustment helps meet the provider’s CMS responsibilities regarding reporting ICD-9-CM codes and successor codes, including:</td>
</tr>
<tr>
<td>20141110.10</td>
<td>171</td>
<td>Maintaining accurate and complete medical records (ICD-9-CM codes must be submitted with proper documentation) Maintaining accurate and complete medical records (ICD-9-CM codes and successor codes must be submitted with proper documentation).</td>
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</table>
It is important for the physician’s office to code each encounter in its entirety; the claim should report the ICD-9-CM code of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.

It is important for the physician’s office to code each encounter in its entirety; the claim should report the ICD-9-CM code and successor codes of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.

Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code on the date of service, and are signed and dated by the physician or physician extender).

Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code and successor codes on the date of service, and are signed and dated by the physician or physician extender).

The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM).

The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM and successor codes).

1st Paragraph – Corrected spelling error from “Prinvate” to private in the first paragraph.

2nd Paragraph – Changed “chhosing” to “choosing”

Removing - BlueCare Plus partners with ValueOptions® of Tennessee to administer behavioral health care services for its BlueCare Plus members. ValueOptions® is responsible for coordinating the provision of covered behavioral health services, establishing and managing a provider network, credentialing and contracting with providers. Providers interested in contracting with ValueOptions® can call 1-800-397-1630. Minimum network criteria required for participation in a ValueOptions® provider network can be found online at http://www.valueoptions.com/providers/Forms/Administrative/Provider_Credentialing_Criteria_Checklist.pdf.

Replacing the name ValueOptions with BlueCare Plus and adding http://www.bcbst.com/providers/contracting-credentialing.page? - BlueCare Plus utilizes ValueOptions® for credentialing and contracting of Behavioral Health Practitioners. All providers who participate in a ValueOptions® network must be credentialed/recredentialed according to ValueOptions® requirements. For a detailed listing of credentialing requirements for practitioners and facilities, visit www.valueoptions.com provider site and select “Forms” or call the National Provider line at 1-800-397-1630.

Removing - Cosmetic Surgery from Non-Covered Benefits; Section C Custodial Care to new section

Created Section E for Cosmetic Surgery

Cosmetic surgery and expenses incurred in connection with the cosmetic surgery are not covered from under Non-Covered Benefits

Addition of the BlueCare Plus Manual Change Document

Replacing “ValueOptions” with BlueCare Plus

Replacing “ValueOptions” with BlueCare Plus

Replacing “ValueOptions” with BlueCare Plus
<table>
<thead>
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<td>77</td>
<td>Replacing &quot;ValueOptions&quot; with BlueCare Plus</td>
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<td>20141110.24</td>
<td>76</td>
<td>Removing &quot;valueoptions.com&quot;</td>
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<tr>
<td>20141110.25</td>
<td>77</td>
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