BlueCare Plus HMO D-SNP℠ Provider Administration Manual
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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 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 HMO D-SNP members.

BlueCare Plus HMO D-SNP 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 BlueCare Plus HMO D-SNP Amendment contained in the BlueCare /TennCare Select 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 are 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, including its licensed affiliate, BlueCare Plus HMO D-SNP.

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 HMO D-SNP 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
- Sustainability
- Outreach
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 HMO D-SNP 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 HMO D-SNP is committed to excellence. Customer service is more than answering questions quickly and correctly. Customer service is the very heart of BlueCare Plus HMO D-SNP, 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 manage 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP is required to explain certain categories in the provider manual. A listing of the topics is included below.

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1. Reporting Obligations
BlueCare Plus HMO D-SNP 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 HMO D-SNP in its data reporting obligations by providing any information that it needs to meet its obligations.

2. Certification of Diagnostic Data
BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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;
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 HMO D-SNP

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 HMO D-SNP is a person-centered approach to coordinated care for special needs members. BlueCare Plus HMO D-SNP 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 HMO D-SNP 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>
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</thead>
<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 HMO D-SNP and it is not permissible to charge a BlueCare Plus HMO D-SNP 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
Providers can use the “I Speak” Language Identification Flash Card to identify the primary language of BlueCare Plus HMO D-SNP 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.

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 HMO D-SNP through collaborative efforts with the Bureau 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 website at http://www.bcbst.com/providers/bluecare-tenncareselect/index.shtml.

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:

BlueCare Plus HMO D-SNP
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>
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<tbody>
<tr>
<td>Provider Relations:</td>
<td></td>
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<tr>
<td>Chattanooga</td>
<td>423-535-6307</td>
<td>Provider Relations 1 Cameron Hill Circle, Chattanooga, TN 37402</td>
</tr>
<tr>
<td>Jackson</td>
<td>731-664-4127</td>
<td>Provider Relations</td>
</tr>
<tr>
<td>Contact</td>
<td>Toll Free or Local Number</td>
<td>Address or Description</td>
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<tr>
<td></td>
<td></td>
<td>51 Stonebridge Blvd. Jackson, TN 38305</td>
</tr>
<tr>
<td>Johnson City</td>
<td>865-588-4640</td>
<td>Provider Relations 801 Sunset Drive, Bldg C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Johnson City, TN 37604</td>
</tr>
<tr>
<td>Knoxville</td>
<td>865-588-4640</td>
<td>Provider Relations 6305 Kingston Pike</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Knoxville, TN 37919</td>
</tr>
<tr>
<td>Memphis</td>
<td>901-544-2138</td>
<td>Provider Relations 85 N. Danny Thomas Blvd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Memphis, TN 38103</td>
</tr>
<tr>
<td>Nashville</td>
<td>615-386-8630</td>
<td>Provider Relations 3200 West End Ave., Ste 102</td>
</tr>
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<td>Nashville, TN 37203</td>
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**Provider Service Line**

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<tbody>
<tr>
<td>Eligibility</td>
<td>1-800-299-1407</td>
<td>Available Monday - Friday</td>
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<td></td>
<td></td>
<td>(except between 7p.m. and 9 p.m. when eligibility</td>
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<td></td>
<td></td>
<td>information is being updated) and Saturday and</td>
</tr>
<tr>
<td>Claims Status</td>
<td></td>
<td>Sunday from 8 a.m. to 4 p.m. The system is not</td>
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<td>available on Thanksgiving Day or Christmas Day.</td>
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**Care Management**

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<tr>
<th>Service</th>
<th>Toll Free or Local Number</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Health Information and Education</td>
<td>1-888-747-8951</td>
<td>Available 24-hours-a-day, 7-days-a-week</td>
<td></td>
</tr>
<tr>
<td>Health Care Counseling</td>
<td>1-800-262-2873</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Behavioral Health</td>
<td>1-866-789-6314</td>
<td>All inpatient and some specific outpatient behavioral health care services require prior authorization.</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Program – Prior Authorization</td>
<td>1-800-935-6103</td>
<td>To arrange behavioral health services</td>
<td></td>
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<tr>
<td>Dental</td>
<td>1-800-332-5762</td>
<td></td>
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<tr>
<td>Enrollment</td>
<td>1-800-924-7141</td>
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<tr>
<td>eBusiness Solutions Technical</td>
<td>423-535-5717</td>
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**State of Tennessee**

<table>
<thead>
<tr>
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<th>Toll Free or Local Number</th>
<th>Description</th>
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<tr>
<td></td>
<td>1-866-311-4287</td>
<td>Bureau of TennCare</td>
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</table>
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 HMO D-SNP operates, however, it will not prevent us from exchanging the information we need for treatment, payment, and health care operations (TPO).

BlueCare Plus HMO D-SNP will continue to conduct business as usual in most circumstances. HIPAA regulations allow disclosure of certain medical information, and BlueCare Plus HMO D-SNP providers (subject to all applicable privacy and confidentiality requirements) are contractually obligated to make medical records of BlueCare Plus HMO D-SNP members available to each Physician and/or Health Care Professional treating BlueCare Plus HMO D-SNP, 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 [http://www.hhs.gov/ocr/hipaa/finalreg.html](http://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 e-mailing us at [http://www.bcbst.com/fraud/index.page](http://www.bcbst.com/fraud/index.page)?

The following information pertains to the Federal False Claims Act:

3 **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,

4. **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.

5. **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.

6. **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.)

7. **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.

8. **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.

9. **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 [http://tn.gov/tnoig/ReportTennCareFraud.html](http://tn.gov/tnoig/ReportTennCareFraud.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.

10. **Education of Employees, Contractors, and Agents – deficit reduction act of 2005**

   If provider receives or makes annual Medicaid payments of $5 million or more then 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.

11. **Reporting Requirements**

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

12. **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](http://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 Payor in the investigation of any Member complaints.

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

BlueCare Plus HMO D-SNP 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 HMO D-SNP.


Providers should identify primary coverage and provide information to BlueCare Plus HMO D-SNP at the time of billing.

BlueCare Plus HMO D-SNP 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 HMO D-SNP program and its responsibility to:

- Identify payers that are primary to BlueCare Plus HMO D-SNP
- 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP is governed by the amount paid by the primary plan. Follow the guidelines below for correct billing:

- When BlueCare Plus HMO D-SNP is primary, submit the claim directly to BlueCare Plus HMO D-SNP
- When BlueCare Plus HMO D-SNP 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 HMO D-SNP, then BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP or its contractor for the same service furnished to the same enrollee on the same date.

- If BlueCare Plus HMO D-SNP learns of the availability of primary insurance after it has made payment to the provider, then BlueCare Plus HMO D-SNP 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 HMO D-SNP to recover a duplicate payment when both BlueCare Plus HMO D-SNP 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 HMO D-SNP notified the provider with a refund request letter that included, at a minimum:
  - Identification of BlueCare Plus HMO D-SNP 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 HMO D-SNP payment and/or appeal the decision;
- Information about how and where to file an appeal with BlueCare Plus HMO D-SNP 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 HMO D-SNP, 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 HMO D-SNP 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 HMO D-SNP has ensured that there is a separate Service Line or Prompt for provider inquiries regarding these recoveries.

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

BlueCare Plus HMO D-SNP  
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 HMO D-SNP and the state to allow for the coordination and/or integration of Medicare and Medicaid benefits.

E. Provider Credentialing

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the adoption of a standard unique identifier for health care providers. The National Provider Identifier (NPI) Final Rule issued January 23, 2004 adopted the NPI as this standard.

The NPI is a 10-digit, intelligence free numeric identifier (10-digit number). Intelligence free means that the numbers do not identify information about health care providers, for example, provider type
and state in which the institution or practice is located. The NPI replaced health care provider identifiers and remains with the provider regardless of job or location changes.

There are two categories of health care providers for NPI enumeration purposes. Entity Type 1 providers are individual providers who render health care (e.g., physicians, dentists, nurses). Sole proprietors and sole proprietorships are Entity Type 1 (Individual) providers. Organization health care providers (e.g., hospitals, home health agencies, ambulance companies) are considered Entity Type 2 (Organization) providers.

Health care providers may apply for an NPI in one of three ways:


- Complete, sign, and mail a paper application form to the NPI Enumerator. For a copy of the application form (CMS- 10114), refer to http://www.cms.gov/cmsforms/downloads/CMS10114.pdf on the CMS website. A hard copy application can be requested through the NPI Enumerator by calling 1-800-465-3203 or TTY 1-800-692-2326.

- If requested, give permission to have an Electronic File Interchange Organization (EFIO) submit the application data on behalf of the health care provider (i.e., through a bulk enumeration process). For more information on this option, see below or visit http://www.cms.gov/NationalProvIdentStand/04_education.asp on the CMS website.

NPI is required on the claim form submitted for reimbursement.

1. Credentialing
The Credentialing Program is designed around goals that reflect the corporate mission, including regulatory and accrediting requirements. In order to establish consistent standards for network participation, and to meet regulatory requirements, BlueCare Plus HMO D-SNP developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application. Utilizing the application, BlueCare Plus HMO D-SNP 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 BlueCare Plus HMO D-SNP network. Major components of the credentialing program include:

- Oversight by the Credentialing Committee
• Policies and Procedures
• Initial Credentialing Process
• Re-credentialing Process
• Delegated Credentialing Activities

Practitioners or organizational providers have the right to review information submitted with their application, correct erroneous information, or be informed of the status of their credentialing 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

E-mail: Credentials@bcbst.com

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

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 HMO D-SNP. The BlueCare Plus HMO D-SNP credentialing standards apply to all licensed independent practitioners or practitioner groups who have an independent relationship with BlueCare Plus HMO D-SNP. The BlueCare Plus HMO D-SNP credentialing program determines whether practitioners and other health care professionals, licensed by the State and under contract to BlueCare Plus HMO D-SNP, 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 from the BlueCross BlueShield of Tennessee (BCBST) Credentialing Department.

Note: This notification does not guarantee acceptance in BlueCare Plus HMO D-SNP 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.

**Applications are considered complete under the following circumstances:**
• The application is filled out in its entirety;
• The statement of the applicant page and/or the attestation page is signed and dated;
• The application is received within 90 days from the date of the statement of the applicant and/or the attestation page; and
• The following documentation is enclosed with the application submission:
  o Explanations to any questions requiring additional information;
  o Copy of the current medical license;
D-SNP

- Copy of the current Drug Enforcement Administration (DEA) / Controlled Dangerous Substance (CDS) certificate, if applicable;
- Copy of the Clinical Laboratory Information Amendments (CLIA) Certificate, if applicable;
- Copy of board certification; if applicable;
- Copy of current business liability certification for (organizational providers only);
- Copy of the current malpractice liability insurance certificate showing $1,000,000 per occurrence and $3,000,000 aggregate coverage to meet BlueCross BlueShield of Tennessee criteria.

Note: The expiration dates for all documents must not be within 90 days of the application’s receipt in the Credentialing Department.

3. Credentialing Policies
BlueCare Plus HMO D-SNP 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.

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).
- Healthcare Integrity and Protection Data Bank (HIPDB) report.
- Board certification verification if the practitioner indicates certified on application.
- BlueCare Plus HMO D-SNP 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 HMO D-SNP credentialed practitioner.

Statement from applicant regarding:
  o Current physical or mental health problems that may affect ability to provide health care;
  o Current chemical dependency/substance abuse;
  o History of loss of license and or felony convictions;
  o History of loss or limitation of privileges or disciplinary activity; and
  o An attestation to correctness/completeness of the application;
  o 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; (See Credentialing XVII.D Practice Site Evaluations/Medical Record Practices.)
  o Verification that practitioner is at office where treatment is rendered and interacts with Nurse Practitioner/Physician Assistant conforming to state regulations;
  o Verification that protocol exists and is located at the premises where Nurse Practitioner/Physician Assistant practices as required by state law.

4. Requirements for specialties listed:

**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:
  - American Occupational Therapy Certification Board;
  - American Speech-Language-Hearing Association;
  - Physical Therapist Certificate of Fitness, if applicable; or
  - 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.

**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).

**Neuropsychologist (Ph.D):**
- Minimum and Exception criteria apply in addition to:
  - Clinical privileges not required.
  - License must specify “Health Services Provider”.
  - Ph. D. degree required.

**Nurse Practitioners or Nurse Mid-Wife:**
- Minimum and Exception criteria apply in addition to:
  - RN License.
  - Advanced Practice Nurse (APN) certificate in TN and applicable prescriptive authority
for contiguous states.

- Certificate of Fitness required for Nurse Practitioners (NP), if applicable.
- 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 HMO D-SNP 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 once a month the practitioner is physically at the offices where treatment is being rendered and is interacting and overseeing the NP; and
  - Verification that a protocol exists and is located at the premises where the NP practices as required by state law.

**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 it must be verified.

**Optometrist:**
Minimum and Exception criteria apply in addition to:

- State license must contain Therapeutic Certification.
- Hospital privileges are not required.

**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 HMO D-SNP 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 once a week the practitioner is physically practicing at the office where treatment is being rendered and is interacting and overseeing the PA; and
  - Verification that a protocol exists and is located at the premises where the PA practices as required by state law.

**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
Minimum and Exception criteria apply in addition to:
- Copy of certification for successful completion of accredited disease specific management program(s), if applicable.
- 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).

Urgent Care Physicians
All Minimum and Exception Criteria apply (unless acting as PCP) with exception of:
- Clinical privileges.
- Call coverage.
- Site visit.

5. Re-credentialing Process
All Medical and Behavioral Health Practitioners will be re-credentialed at a minimum of every three (3) 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 HMO D-SNP 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. Providers are sent a re-credentialing application that must be completed in its entirety, signed and returned to Tennessee as soon as possible, with all requested information attached.

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.

6. Provider Qualifications and Requirements
In order to be paid by BlueCare Plus HMO D-SNP for services provided to one of our members, you must:
- Have a National Provider Identifier in order to submit electronic transactions to BlueCare Plus HMO D-SNP, in accordance with HIPAA requirements.
- Furnish services to a BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 under any condition, including in the event of plan bankruptcy.

## F. 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 www.bcbst.com/providers/ecomm/technicalinformation.shtml.

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:
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>The BlueCross BlueShield of Tennessee SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports</td>
</tr>
<tr>
<td>FTP/SSL (server mftsftp.bcbst.com)</td>
<td>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.</td>
</tr>
</tbody>
</table>

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/ecomm/technical-information.shtml.

*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/technical-information.shtml.

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.

G. BlueCare Plus HMO D-SNP Website

1. Provider Resources
BlueCare Plus HMO D-SNP integrates self-service and electronic communication technologies as an efficient, cost-effective means to distribute BlueCare Plus HMO D-SNP 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.

The Website redesign 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 design. Please let us know through our member/provider survey available on BlueCare Plus HMO D-SNP home page about your experience.

Figure 1 BlueCare Plus Website Home Page

The following provider resource sections are available on the 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.

**Figure 2 Providers 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 is 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
C-Prior authorizations
• View and/or print your remittance advice
• Available on bluecareplus.bcbst.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 HMO D-SNP

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.

Figure 3 BlueAccess
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”.

Figure 4 BlueAccess Register Now
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:
  o Claims;
  o Prior authorizations; and
  o Referrals
  o 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:
Figure 6 BlueAccess Provider Services

Keeping Data Secure with Encryption

BlueCare Plus HMO D-SNP 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

BlueAccess_Registration.pdf

H. Member or Representative Appeals and Grievances

BlueCare Plus HMO D-SNP 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
Member concerns, complaints, and resolutions, if applicable, are documented and maintained by BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP, 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP, provider, or facility. An expedited grievance may also include a complaint that BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP;
- 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 HMO D-SNP 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/Personally Identifiable Information (PHI/PII): (45 C.F.R. § 160.103; OMB Circular M-06-19 located at http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf) – 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 HMO D-SNP 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 HMO D-SNP 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, Bureau 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 HMO D-SNP members or their representatives;
  - Have the right to request an expedited reconsideration
  - The right to request and receive appeal data from BlueCare Plus HMO D-SNP
  - 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 HMO D-SNP upholds its 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 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 HMO D-SNP. 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 HMO D-SNP.
- 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 HMO D-SNP.

Below is a quick reference guide for the processes;

2. Appeal Levels

Level 1 Appeal

BlueCare Plus HMO D-SNP

Dissatisfied with determination by BlueCare Plus HMO D-SNP

- Member or representative may request an appeal
- Send request for reconsideration to:
  BlueCare Plus HMO D-SNP 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:
  - 30 days if the decision involves a request for service
  - 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 HMO D-SNP 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.
  - the member's appeal to an independent outside entity for a Level 2 review. If BlueCare Plus HMO D-SNP does not meet the response deadline it will forward the appeal to an independent outside entity for a Level 2 review.
  - If during the Level 1 appeal BlueCare Plus HMO D-SNP does not decide in the member or representative’s favor, it is required for BlueCare Plus HMO D-SNP 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:
  - BlueCare Plus HMO D-SNP does not meet the response deadline
  - Unfavorable redetermination
- After the IRE has reviewed the case it will send a notice of its decision in the mail.
  - The IRE notice will include detailed information about the right to appeal to OMHA (Level 3). You may appeal to Level 3 if:
    - Dissatisfied with IRE decision
    - Amount in controversy is $140 (2013) or more (this amount may change annually)
    - 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
  - 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:
- Beneficiary’s name;
- Name of the health services provider;
- Date and type of service;
- Medicare contractor or managed care organization that issued the initial determination in a member’s case; Health Insurance Claim Number (HICN);
- OMHA appeal number;
- Date of the Administrative Law Judge (ALJ) decision or dismissal;
- An appointment of representative, such as CMS Form 1696 (PDF, 66.4 KB) (if applicable);
- Any additional evidence, clearly marked as new or duplicate; and
- 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
  - 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
  - Last level of appeals
Figure 7 Amount in controversy is subject to change annually

Organization Determination/Appeal Process
Quick Reference Guide

Organization Determination

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

Expedited Process
- Pre-Service: 72 hour time limit
- Payment: 60 day time limit

First Appeal Level

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

BlueCare Plus Reconsideration
- 72 hour time limit
- Payment requests cannot be expedited

Automatic forwarding to IRE if BlueCare PLUS upholds denial

Second Appeal Level

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

IRE Reconsideration
- 72 hour time limit
- Payment requests cannot be expedited

60 days to file

Third Appeal Level

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

60 days to file

Fourth Appeal Level

Medicare Appeals Council
No statutory time limit for processing

60 days to file

Fifth Appeal Level
(Judicial Review)

Federal District Court
Threshold $1,400

60 days to file

*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 an 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/CMS-Forms-Items/CMS012207.html.
Figure 8 CMS 1696 Appointment of Representative
For Spanish version visit The Centers for Medicare and Medicaid Forms page.
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 HMO D-SNP 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.bcbs.com/docs/providers/UM_Advance_Determination_Request_Fax.pdf and fax it to 1-866-325-6698. BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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). However, 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 HMO D-SNP denies a request for payment from a non-contract provider, BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP, 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 HMO D-SNP can help individuals manage all services and providers. A non-qualifying individual that disenrolls from BlueCare Plus HMO D-SNP may re-enroll if the individual once again meets the specific qualifying characteristic(s) of BlueCare Plus HMO D-SNP. If an individual joins BlueCare Plus HMO D-SNP 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 HMO D-SNP
- 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 HMO D-SNP through;
- Online Enrollment Center [http://bluecare.bcbst.com](http://bluecare.bcbst.com)
- Calling BlueCare Plus HMO D-SNP
  - 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 HMO D-SNP 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 HMO D-SNP if the member continues to meet the chronic SNP served by BlueCare Plus HMO D-SNP. As a D-SNP program, all our members qualify for the Special Election Period (SEP) every month. The SEP permits our member to enroll or disenroll throughout the year. For more information regarding the Special Election Period visit [bluecareplus.bcbst.com](http://bluecareplus.bcbst.com) or [www.cms.gov](http://www.cms.gov). A member may be disenrolled if the member loses Medicaid eligibility.

A BlueCare Plus HMO D-SNP 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 HMO D-SNP
- Calling 1-800-MEDICARE or visiting [www.medicare.gov](http://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

<table>
<thead>
<tr>
<th>State</th>
<th>Physician Services</th>
<th>Hospital and Ancillary Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tennessee</td>
<td>Bill TennCare for cost sharing</td>
<td>Bill TennCare for cost sharing</td>
</tr>
</tbody>
</table>

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:

http://www.tn.gov/tenncare/providers.shtml
http://www.tn.gov/tenncare/members.shtml
http://www.tn.gov/tenncare/longtermcare.shtml

Providers should refer to the TennCare Bureau Medicare and Medicaid Crossover Claims directions outlined on the TennCare Bureau web site at http://www.tn.gov/tenncare/pro-claims.shtml for claims submission requirements.

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**BlueCare Plus HMO D-SNP**

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<thead>
<tr>
<th>Description</th>
<th>Provider Cost Sharing</th>
<th>Member Cost Sharing</th>
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<td>Premium</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>60 lifetime reserve days</td>
<td>and 60 lifetime reserve</td>
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<td>Inpatient Mental Health Care</td>
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<tr>
<td>Description</td>
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<td>Diagnostic Tests, X-Rays, Lab, and Therapeutic radiology</td>
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<td>Preventive Services and Wellness/Education Programs</td>
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<td>Description</td>
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<td>Member Cost Sharing</td>
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<td><strong>Description</strong></td>
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<td>Physical Exams</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>ESRD/Dialysis</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formulary</td>
<td>4T Closed</td>
<td>4T Closed</td>
</tr>
<tr>
<td>B-covered drugs</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>(not including chemotherapy drugs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B-covered chemotherapy drugs</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine</td>
<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>
<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>
<tr>
<td>Comprehensive</td>
<td>$250 coverage limit at the beginning of every qtr with rollover of balance until 12/31 and restarting at 1/1 each year. The coverage limit is applicable to routine and comprehensive services.</td>
<td>$250 coverage limit at the beginning of every quarter with rollover of balance until 12/31 and restarting at 1/1 each year. The coverage limit is applicable to routine and comprehensive services.</td>
</tr>
<tr>
<td>Medicare covered</td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td>Hearing Services -</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### BlueCare Plus HMO D-SNP

<table>
<thead>
<tr>
<th>Description</th>
<th>Provider Cost Sharing</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare covered only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td><strong>routine</strong></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>

### Vision Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Provider Cost Sharing</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare covered only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Standard Part B Cost Sharing</td>
<td>Zero Cost Sharing</td>
</tr>
<tr>
<td><strong>glasses/contacts (eyewear)</strong></td>
<td>$300 allowance / every yr</td>
<td>$300 allowance / every yr</td>
</tr>
<tr>
<td><strong>routine exam</strong></td>
<td>$0 copay for one exam each yr</td>
<td>$0 copay for one exam each yr</td>
</tr>
</tbody>
</table>

### Wellness/Education and Other Supplemental Benefits & Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Provider Cost Sharing</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Club Membership/Fitness Classes</strong></td>
<td>Silver Sneakers</td>
<td>Silver Sneakers</td>
</tr>
<tr>
<td><strong>24 Hour Nursing Hotline</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Over-the-Counter Items</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTC Catalog</strong></td>
<td>$150 allowance / every qtr</td>
<td>$150 allowance / every qtr</td>
</tr>
</tbody>
</table>

### Transportation

<table>
<thead>
<tr>
<th>Description</th>
<th>Provider Cost Sharing</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Acupuncture and Other Alternative Therapies

<table>
<thead>
<tr>
<th>Description</th>
<th>Provider Cost Sharing</th>
<th>Member Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine</strong></td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

### Additional Benefits

<table>
<thead>
<tr>
<th>Description</th>
<th>Original Medicare</th>
<th>BlueCare Plus HMO D-SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AA.</strong> Wellness and Discount Program</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><strong>BB.</strong> Exercise Program</td>
<td>Not available</td>
<td>Nation’s leading exercise program with Silver Sneakers**</td>
</tr>
<tr>
<td><strong>CC.</strong></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 HMO D-SNP 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.

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**D. Member ID Cards**

![Member ID Card Sample]
Figure 9 BlueCare Plus HMO D-SNP ID Card

BlueCare Plus HMO D-SNP members should receive a 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 HMO D-SNP Website at bluecareplus.bcbst.com or contacting the BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP PCPs have agreed to fulfill special roles and responsibilities associated with the management and care of BlueCare Plus HMO D-SNP members. In return for the additional efforts in caring for BlueCare Plus HMO D-SNP 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 HMO D-SNP 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</td>
</tr>
</tbody>
</table>
The Primary Care Provider change is considered initiated when:

- A member calls in a PCP change request to BlueCare Plus HMO D-SNP Customer Service line;
- A member mails in a written PCP change request to BlueCare Plus HMO D-SNP Customer Service;
- A member mails a postage-paid PCP Change Card to BlueCare Plus HMO D-SNP (cards are available in the Member’s BlueCare Plus HMO D-SNP Directory and BlueCare Plus HMO D-SNP Member Handbook or
- PCP Change Form faxed to BlueCare Plus HMO D-SNP are only accepted if the member is:
  - New to BlueCare Plus HMO D-SNP or in need of help submitting the change.
  - 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:

  BlueCare Plus HMO D-SNP
  1 Cameron Hill, Circle Ste 0002
  Chattanooga, TN 37402-9025
  Fax to BlueCare Plus PCP Department
  1-888-261-9025

  Attention: PCP Change Team
BlueCare
Tennessee

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_W14_DPCFPRM (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.

Medicare coverage and payment is contingent upon a determination that:

A service meets a benefit category;
A service is not specifically excluded from Medicare coverage by the Act; and

The item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member, or is a covered preventive service.

The criteria are codified through rulemaking in the Code of Federal Regulations and/or applied in manual guidance, or are applied through coverage determinations. National Coverage Determinations (NCDs) and are published on the National Coverage Web site.

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. (See section 90.2 below for more detailed guidance on the obligation of plans to follow local coverage determination.

BlueCare Plus is a full-benefit HMO D-SNP that enrolls individuals who are eligible for:

1. Medical assistance for full Medicaid benefits for the month under any eligibility category covered under the Medicaid State Plan or comprehensive benefits under a demonstration under Section 1115 of the Act; or,
2. Medical assistance under Section 1902(a)(10)(C) of the Act (Medically Needy) or Section 1902(f) of the Act (States that use more restrictive eligibility criteria than are used by the SSI program) for any month if the individual was eligible for medical assistance in any part of the month.

BlueCare Plus HMO D-SNP must confirm eligibility, including both MA eligibility and Medicaid eligibility prior to enrollment into the D-SNP. Acceptable proof of Medicaid eligibility can be a current Medicaid card, a letter from the state agency that confirms entitlement to Medical Assistance, or verification through a systems query to a State eligibility data system.

A D-SNP enrollee’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 a D-SNP 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.

If BlueCare Plus HMO D-SNP has no reasonable expectation that an individual, who has lost his/her special needs status, will regain that status within a short period, as determined by BlueCare Plus HMO D-SNP, then BlueCare Plus HMO D-SNP must disenroll the individual in accordance with guidance in Chapter 2 of the Medicare Managed Care Manual. The expected period of loss of eligibility cannot exceed six months.

For the period of deemed continued eligibility, BlueCare Plus HMO D-SNP must continue to provide all appropriate MA plan covered benefits. BlueCare Plus HMO D-SNP is not responsible for changes in Medicaid eligibility or providing benefits that are included under the applicable Medicaid State Plan, nor is BlueCare Plus HMO D-SNP responsible for Medicare premiums or cost sharing for which the State would otherwise be liable.

B. Emergent and Urgently Needed Care

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 in this section but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;

- Are provided when the member is temporarily absent from the BlueCare Plus HMO D-SNP service area (or, if applicable, continuation) area, or under unusual and extraordinary circumstances, when the enrollee is in the service or continuation area, and the network is temporarily unavailable or inaccessible; and

It was not reasonable given the circumstances to wait to obtain the services through the plan network.

**Stabilization of an Emergency Medical Condition**

The physician treating the member must decide when the member may be considered stabilized for transfer or discharge. Section H. Member or Representative Appeals and Grievances, of this manual, addresses the member’s right to request a Quality Improvement Organization review of hospital discharges to a lower level of care. For transfers from one inpatient setting to another inpatient setting, a member or person authorized to act on his or her behalf who disagrees with the decision and believes the member cannot safely be transferred may request that the organization pay for continued out-of-network services. If the BlueCare Plus HMO D-SNP declines to pay for the services, appeal rights are available to the member.

**Post Stabilization Care Services**

Are covered services that are:

- Related to an emergency medical condition;
- Provided after an member is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances (see below), to improve or resolve the member’s condition.

Members’ charges for post-stabilization care services may not be greater than what would be charged to the enrollee if she/he had obtained the services through BlueCare Plus HMO D-SNP. For purposes of cost-sharing, post-stabilization care, services begin when the patient is stabilized and the emergency ends.

**C. Services, Supplies and Durable Medical Equipment (DME)**

Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits or enables the member to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions and/or illnesses. DME considered as equipment, which can withstand repeated use and is primarily and customarily used to serve a medical purpose. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. There are
items, although durable in nature, which may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs and eyes.

BlueCare Plus HMO D-SNP ensures that members have access to all medically necessary (including non-preferred) DME products or brands;

Contracted suppliers provide access to all preferred DME brands;

Although BlueCare Plus HMO D-SNP may add brands to its preferred formulary during the year, it does not remove any brands midyear;

BlueCare Plus HMO D-SNP treats denials of non-preferred DME products or brands as organization determinations. DME coverage limitations and member appeal rights in the case of a denial of a non-preferred DME product or brand as packaged with the Evidence of Coverage and Annual Notice of Change is available on the BlueCare Plus Website.

Basic information needed for processing an advance organization determination request:

- Member’s identification number and name;
- 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:
  - Member’s diagnosis and expected prognosis;
  - Copy of certificate of medical necessity and signed prescription;
  - Estimated duration of use;
  - Limitations and capability of the member to use the equipment;
  - Itemization of the equipment components, if applicable;
  - Appropriate HCPCS codes for equipment being requested; and
  - Member’s weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

**Orthotics/Prosthetics**

Basic information needed for processing an advance determination or prior authorization 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:
  - Member’s diagnosis and expected prognosis;
Limitations and capability of the member to use the equipment;
Itemization of the equipment components, if applicable; and
Appropriate HCPCS codes for equipment being requested.

Retrospective Review

BlueCare Plus HMO D-SNP 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
- Milliman Care Guidelines
- BlueCare Plus HMO D-SNP adopted guidelines

D. Chiropractic Services

Coverage of chiropractic service is specifically limited to treatment by means of manual manipulation, i.e., by use of the hands. 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 HMO D-SNP coverage and payment are not available for those services.

The word “correction” may be used in lieu of “treatment.” Also, a number of different terms composed of the following words may be used to describe manual manipulation as defined above:

- Spine or spinal adjustment by manual means;
- Spine or spinal manipulation;
- Manual adjustment; and
- Vertebral manipulation or adjustment.

Documentation Requirements: Initial Visit

The following documentation requirements apply whether the subluxation is demonstrated by x-ray or by physical examination:

History as stated above.
Description of the present illness including:
Mechanism of trauma;
Quality and character of symptoms/problem;
Onset, duration, intensity, frequency, location, and radiation of symptoms;
Aggravating or relieving factors;

Prior interventions, treatments, medications, secondary complaints; and
Symptoms causing patient to seek treatment

These symptoms must bear a direct relationship to the level of subluxation.

Evaluation of musculoskeletal/nervous system through physical examination.

Diagnosis: The primary diagnosis must be subluxation, including the level of subluxation, either so
stated or identified by a term descriptive of subluxation. Such terms may refer either to the
condition of the spinal joint involved or to the direction of position assumed by the particular bone
named.

Treatment Plan: The treatment plan should include the following:

- Recommended level of care (duration and frequency of visits);
- Specific treatment goals; and
- Objective measures to evaluate treatment effectiveness.

Date of the initial treatment.

Subsequent Visits

The following documentation requirements apply whether the subluxation is demonstrated by x-ray
or by physical examination:

History
- Review of chief complaint;
- Changes since last visit;
- System review if relevant.

Physical exam
- Exam of area of spine involved in diagnosis;
- Assessment of change in patient condition since last visit;
- Evaluation of treatment effectiveness.

Documentation of treatment given on day of visit.

E. Drugs Under Original Medicare

For this section, the term “drug” means “drug or biological”.

BlueCare Plus HMO D-SNP provides our members with coverage of all drugs covered under
original Medicare Part B. Part B Medicare covers drugs in a limited number of cases including the
following:
• Drugs that the Medicare cost plan enrollee takes while using durable medical equipment (such as nebulizers) that were authorized by the enrollee’s Medicare cost plan;
• Clotting factors if the enrollee is diagnosed with specific blood-clotting disorders;
• Immunosuppressive drugs, if the enrollee had an organ transplant that was covered by Medicare;
• Injectable osteoporosis drugs, if the enrollee has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug;
• Antigens;
• Certain oral anti-cancer drugs and anti-nausea drugs; and
• Erythropoietin by injection if the member has end-stage renal disease and needs this drug to treat anemia.

• Not Usually Self-Administered (NUSA) Drugs. If a drug is defined as:
  (a) not usually self-administered (NUSA) by the carrier in the area covered by the BlueCare Plus HMO D-SNP, and;
  (b) the drug is delivered incident to a physician service, then it is classified as a Medicare-covered drug under Part B.

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

F. Hospice

Reimbursement for hospice services is considered a carve-out and not payable under BlueCare Plus HMO D-SNP. These services should be billed to Original Medicare for reimbursement.

A BlueCare Plus HMO D-SNP member who elects hospice care but chooses not to disenroll from the plan is entitled to continue to receive through BlueCare Plus HMO D-SNP any benefits other than those that are the responsibility of the Medicare hospice. Through the Original Medicare program, subject to the usual rules of payment, CMS pays the hospice program for hospice care furnished to the member and BlueCare Plus HMO D-SNP, providers, and suppliers for other Medicare-covered services furnished to the enrollee.

The term “hospice care” refers to Original Medicare items and services related to the terminal illness for which the member entered hospice. The term “non-hospice care” refers either to services not covered by Original Medicare or to services not related to the terminal condition for which the enrollee entered the hospice.

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 HMO D-SNP service area and cannot reasonably access the BlueCare Plus HMO D-SNP providers. No prior authorization is required however, the member is encouraged to advise BlueCare Plus HMO D-SNP if he/she will be temporarily out of the service area.
H. Referral Guidelines

Non-urgent and non-emergent out-of-network services require a PCP referral and plan approval. A PCP or member may initiate a prior authorization request for approval for scheduled out-of-network care by submitting (via mail or fax) a Request for Out-of-Network Benefits form to the Utilization Management department, please follow the link to the fax numbers and mail suites.

In BlueCare Plus HMO D-SNP, 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 HMO D-SNP members’ health care and routine health care needs.

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 network provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as provided from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when a member may be temporarily outside of the BlueCare Plus HMO D-SNP 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. (If possible, members should call Member Services before they leave the service area so BlueCare Plus HMO D-SNP can help arrange for the members to have maintenance dialysis while they are away. Contact Member Services for additional information 1-800-332-5762.

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 HMO D-SNP 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 lead 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 HMO D-SNP population. BlueCare Plus HMO D-SNP 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 HMO D-SNP**

1-866-789-6314

**Provider Network Participation**

Please be aware not all disciplines described are eligible for participation in the BlueCare Plus HMO D-SNP 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 HMO D-SNP members.

If you have questions about network eligibility, please contact your assigned regional BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP members should call the appropriate Provider Service line listed below, or BlueCare Plus HMO D-SNP 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 HMO D-SNP primary care provider seeking psychiatric consultation services.

In the event of a crisis, BlueCare Plus HMO D-SNP 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

In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, we cover:

- Two routine oral exams and two teeth cleanings per year
- One set of dental X-rays per year

We also cover the following comprehensive dental benefits (emergency, diagnostic, and restorative care)

- Up to $250 every three months. Unused amounts carry over from one 3-month period to the next, except that any unused amounts expire on December 31 of every year
- $0 copayment for routine dental services (oral exams, teeth cleaning, dental X-rays)

Members pay the costs of comprehensive services over the benefit limit or when obtained from non-participating providers.

No prior authorization is required for preventive services.

V. Non-Covered Benefits

A. Overview

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. The four categories described below are not covered under Original Medicare and are therefore not covered under BlueCare Plus HMO D-SNP.

- Services and supplies that are not medically reasonable and necessary;
- Excluded items and services;
- Services and supplies that have been denied as bundled or included in the basic allowance of another services;
- Items and services reimbursable by other organizations or furnished without charge.

Services and Supplies that are not Medically Reasonable and Necessary

- Services furnished in a hospital or Skilled Nursing Facility (SNF) that, based on the member's condition, could have been furnished elsewhere (e.g., the beneficiary's home or a nursing home);
- Evaluation and management services that are in excess of those considered medically reasonable and necessary;
- Therapy or diagnostic procedures that are in excess of Medicare usage limits;
Screening tests and examinations for which the beneficiary has no symptoms or documented conditions, with the exception of certain preventive screening tests and examinations as described below under Exceptions to Exclusion; Services not warranted based on the diagnosis of the member (e.g., biofeedback therapy, acupuncture, and transcendental meditation); and

**Services and supplies are considered medically necessary if they:**

- Are proper and needed for the diagnosis or treatment of the member’s medical condition;
- Are furnished for the diagnosis, direct care, and treatment of the member’s medical condition;
- Meet the standards of good medical practice; and
- Are not mainly for the convenience of the member, provider, or supplier

## B. Exceptions to Exclusion

The following preventive screening tests and examinations are covered when certain coverage requirements are met:

- **Initial Preventive Physical Examination (IPPE) (also known as the “Welcome to Medicare Visit”):**
  - Welcome to Medicare Preventive Visit one time service and must be furnished no later than 12 months after the effective date of the first Medicare Part B coverage
- **Annual Wellness Visit;** (AWV)
- **All BlueCare Plus HMO D-SNP members who are no longer within 12 months after the effective date of their first Medicare Part B coverage period and who have not received an IPPE or AWV within the past 12 months**
  - G0438 – Initial visit
  - G0439 – Subsequent visit
- **Colorectal cancer screening:**
  - All BlueCare Plus HMO D-SNP members aged 50 and older who are:
    - At normal risk of developing colorectal cancer, or
    - At high risk of developing colorectal cancer
- **Screening mammography:**
  - All female BlueCare Plus HMO D-SNP aged 35 and older one baseline
  - Aged 40 and older annually
- **Screening Pap tests:**
  - All female BlueCare Plus HMO D-SNP members
    - Annually if at high risk, abnormal Pap test within past 3 years
    - Every 24 months for all other women
- **Screening pelvic examinations:**
  - All female BlueCare Plus HMO D-SNP
    - Annually if at high risk, abnormal Pap test within past 3 years
    - Every 24 months for all other women
- **Prostate cancer screening:**
  - All male BlueCare Plus HMO D-SNP members aged 50 and older (coverage begins the day after 50th birthday)
- Annually
  - Cardiovascular screenings;
    - All BlueCare Plus HMO D-SNP members without apparent signs or symptoms of cardiovascular disease
    - Every 5 years
  - Diabetes screening tests;
    - BlueCare Plus HMO D-SNP members with certain risk factors for diabetes or diagnosed with pre-diabetes
    - Members previously diagnosed with diabetes are not eligible for this benefit
    - Two screening tests per year for members diagnosed with pre-diabetes
    - One screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested
  - Glaucoma screening;
    - BlueCare Plus HMO D-SNP members with diabetes mellitus, family history of glaucoma, African-Americans aged 50 and older, or Hispanic-Americans aged 65 and older
    - Annually for covered members
  - Human Immunodeficiency Virus (HIV) screening;
    - BlueCare Plus HMO D-SNP members who are at increased risk for HIV infection
    - Annually for members at increased risk
  - Bone mass measurements
    - Certain BlueCare Plus HMO D-SNP members that fall into at least one of the following categories:
      1. Women determined by their physician or qualified non-physician practitioner to be estrogen deficient and at clinical risk for osteoporosis
      2. Individuals with vertebral abnormalities
      3. Individuals receiving (or expected to receive) glucocorticoid therapy for more than 3 months
      4. Individuals with primary hyperparathyroidism
      5. Individuals being monitored to assess response to FDA-approved osteoporosis drug therapy
      - Every 24 months
      - More frequently if medically necessary
  - Ultrasound screening for abdominal aortic aneurysm (AAA)
    - Certain BlueCare Plus HMO D-SNP members with certain risk factors for AAA
    - Eligible members must receive a referral for an ultrasound screening for AAA as a result of an IPPE

Excluded Items and Services

- Most items and services furnished outside the U.S. will not be covered. Payment will not be made for a medical service (or portion thereof) that was subcontracted to another provider or supplier located outside the U.S.
- Items and services that are required as a result of war or an act of war and that occur after the effective date of the beneficiary’s current entitlement date are not covered
- Personal comfort items and services
• Routine Services and appliances that are performed without a specific sign, symptom or member complaint
• Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses;
• Eye refractions furnished by all practitioners for any purpose
• Eyeglasses and contact lenses
• Examinations for hearing aids
• Hearing aids; and
• Immunizations

Exceptions to Exclusions

• Physician services performed in conjunction with an eye disease (e.g., glaucoma and cataracts)
• Services performed incident to physician services in conjunction with an eye disease
• Vaccinations directly related to the treatment of an injury or direct exposure to a disease or condition (e.g., antirabies treatment and immune globulin);
• Vaccinations that are specifically covered by statute (e.g., seasonal influenza virus, pneumococcal, and Hepatitis B);
• A reasonable supply of antigens (i.e., not more than a 12-week supply that has been prepared for a particular beneficiary) that a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) has prepared after examining the beneficiary and determining a plan of treatment and dosage regimen. A different physician may administer the antigens; and
• Certain devices that produce perception of sound by replacing the function of the middle ear, cochlea, or auditory nerve and are indicated only when hearing aids are medically inappropriate or cannot be utilized due to:
  
  Congenital malformations;
  Chronic disease;
  Severe sensorineural hearing loss; or
  Surgery

C. Custodial Care

Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel and serves to assist an individual in the activities of daily living. Custodial care is non-covered. The following activities are examples of custodial care:

• Walking;
• Getting in and out of bed;
• Bathing;
• Dressing;
• Feeding;
• Using the toilet;
• Preparing a special diet; and
• Supervising the administration of medication that can usually be self administered.
D. Certain Foot Care Services and Supportive Devices for the Feet

The following foot care services and devices are generally excluded from coverage, except as described below under Exceptions to Exclusion:

- Treatment of flat foot;
- Routine foot care, which includes:
  - The cutting or removal of corns and calluses;
  - The trimming, cutting, clipping, or debriding of nails; and
  - Other hygienic and preventive maintenance care (e.g., cleaning and soaking the feet, use of skin creams to maintain skin tone of either ambulatory or bedridden patients, and any other service performed in the absence of localized illness, injury, or symptoms involving the foot); and
  - Orthopedic shoes and other supportive devices for the feet.

E. 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.

F. Items and Services Reimbursable by Other Organizations or Furnished Without Charge

Payment will not be made if payment has been made or can reasonably be expected to be paid promptly under:

- Automobile insurance;
- No-fault insurance;
- Liability insurance; or
- Workers’ Compensation (WC) law or plan of the U.S. or a State.

G. Self-Administered Drugs and Biologicals

Sometimes members need "self-administered drugs and Part B of Original Medicare generally does not pay for self-administered drugs. The term "administered" refers only to the physical process by which the drug enters the patient's body. Injectable drugs, including intravenously administered..."
drugs, are typically eligible for inclusion under the “incident to” benefit. With limited exceptions, other routes of administration including, but not limited to, oral drugs, suppositories, topical medications are considered to be usually self-administered by the patient.

For certain injectable drugs, it will be apparent due to the nature of the condition(s) for which they are administered or the usual course of treatment for those conditions, they are, or are not, usually self-administered. For example, an injectable drug used to treat migraine headaches is usually self-administered. On the other hand, an injectable drug, administered at the same time as chemotherapy, used to treat anemia secondary to chemotherapy is not usually self-administered.

For the purposes of applying this exclusion, the term “usually” means more than 50 percent of the time for all Medicare beneficiaries who use the drug. Therefore, if a drug is self-administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage and the contractor may not make any Medicare payment for it. In arriving at a single determination as to whether a drug is usually self-administered, contractors should make a separate determination for each indication for a drug as to whether that drug is usually self-administered.

BlueCare Plus HMO D-SNP adheres to the Cahaba Government Benefit Administrators, LLC Self-Administered Drug (SAD) Exclusion List.

H. Cosmetic Surgery

Cosmetic surgery and expenses incurred in connection with the cosmetic surgery are not covered.

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 National Coverage Determinations Manual published by CMS describes whether specific medical items, services, treatment procedures, or technologies can be paid is located at
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 HMO D-SNP abides by The CMS payment policies and NCDs. In the absence of an NCD BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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.

Note: The example above is an excerpt from the CMS CCI code table located at 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.

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**II. Pharmacy**

In addition to coverage for Part D drugs, BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP members under Medicaid benefits. The member may contact Medicaid for more information about drugs covered under their Medicaid coverage.

BlueCare Plus HMO D-SNP 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.)
BlueCare Plus HMO D-SNP offers a “List of Covered Drugs (Formulary)” available on the BlueCare Plus HMO D-SNP 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 HMO D-SNP 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:

BlueCare Plus HMO D-SNP
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 HMO D-SNP 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.

**Formulary Exception**

Ensures that members have access to medically necessary Part D drugs that are not included on the BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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;

- The prescription drug alternative(s) listed on BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 form.

If an exception is granted, BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP plan member receives a BlueCare Plus HMO D-SNP 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 HMO D-SNP ID plan by simply checking his/her member ID card. When a BlueCare Plus HMO D-SNP 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
VIII. Model of Care (MOC) D-SNP

A. Overview

BlueCare Plus HMO D-SNP 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 HMO D-SNP 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

The administrative staff coordinates benefits, plan information, data collection and analysis for members, network providers, and the public. The service delivery staff performs clinical functions; maintaining a coordinated care management process, education and clinical care. While both administrative 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP visit our website, bluecareplus.bcbst.com.

Credentialing occurs initially during the application process for any provider applying to participate in the BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP offers a self study and attestation through the BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP.

BlueCare Plus HMO D-SNP 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 HMO D-SNP.

**G. Provider Education and Ongoing Training**

BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP program. Methods include print, the
provider resources section of the website at bluecareplus.bcbst.com, face to face instruction, web based training and presentations.

The Blue Source Provider Information CD is a single source tool for the provider community. To access important billing and reimbursement guidelines, review upcoming medical policies, verify covered medications and much more. Providers and suppliers will receive the CD through certified mail quarterly.

If for some reason you do not receive the CD quarterly, contact your Provider Network Manager. BlueCare Plus HMO D-SNP will also include updates or changes to the program including MOC training in the monthly BlueAlert Provider News Flash newsletter.

**H. Health Needs Assessment**

At enrollment, BlueCare Plus HMO D-SNP identifies a member’s health status through an initial health needs assessment (HNA). The assessment identifies medical, psychosocial, functional 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 HMO D-SNP 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 Plan of Care (POC)**

A clinical Care Coordinator develops a comprehensive individualized care plan in collaboration with the member and/or member’s caregiver. This is done prior to the first ICT meeting in an effort to gather information that participant of the ICT will need in order to make decisions about a member’s health care services, determine if the stratification level is accurate, modify the care plan if needed, and coordinate appropriate care and necessary care.

The role of the Care Coordinator is not only to support members and caregivers, it is also to support the PCP in managing and coordinating care. Our intent is to bear some of the administrative burden and assist the member’s PCP in obtaining information he or she needs, keeping the PCP informed of pertinent information, and helping the PCP to coordinate and manage his or her member’s care.

All BlueCare Plus HMO D-SNP members will have an assigned Care Coordinator, and individualized care plan and his or her personal ICT. The care plan will include goals, objectives, specific services, outcome measures that are established by the ICT as well as a member’s preference for services. The PCP, ICT participants, and other treating providers will receive a copy of the care plan. 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.
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.

The purpose of the ICT is to bring all providers who are treating a member together to discuss the member’s health care needs, gaps in care, medications, and necessary services. The ICT is intended to bring about awareness to all providers who are treating the member regarding all services the member is receiving.

By having all appropriate parties, "at the table", we anticipate outcomes of the ICT will include:

- 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

A Care Coordinator will collaborate with a member or caregiver to determine his or her preference for the composition of the ICT; however, the PCP and other treating providers should participate in the ICT in order to have the most impact on a member’s health status.

ICT meetings will be conducted whether by teleconferencing, videoconferencing electronically or by fax, if the PCP prefers, during an office visit teleconferencing other participants into the meeting. The frequency of the meetings is dependent upon a member’s health risk and status. ICT meetings should occur at least every six (6) months for risk members, at least annually for members who have moderate or low health risk, and may also occur when a member’s health status changes.

Our Care Management team will work with the PCP to schedule ICT reviews and will prepare an ICT document with a member’s care plan, pertinent labs or test results, and other health information. The document will be sent to the PCP and other ICT participants prior to an ICT meeting for their review in an effort to conduct concise and informative reviews that will benefit the PCP’s management of a member’s care and the member will have a "roadmap" of their health care plan.

The BlueCare Plus health needs assessment (HNA, interdisciplinary care team (ICT) information and the physician assessment form (PAF) is now combined into one document to abridge the ICT process for the PCP practice. The document is **prepopulated**, to the extent possible, and ready for review for any additions/changes and PCP attestation. The method of reviewing the document will be determined by the PCP and Care Coordinator.

To assist the PCP in caring for and managing his or her patients and our members, PCP participation in his or her member’s ICT is **crucial**; therefore, BlueCare Plus HMO D-SNP will reimburse the provider for each ICT meeting they participate in. 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 are encouraged to participate in case rounds if contacted.

K. Performance and Health Outcome Measurement

BlueCare Plus HMO D-SNP 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, newsletters and announcements. BlueCare Plus HMO D-SNP will utilize an electronic messaging system and the 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 HMO D-SNP program.

Established quantitative measures evaluate performance for issues identified in the HRA 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; part of the measurement of clinical practice guidelines or disease management systems, or other issues that are relevant to the population. This provides BlueCare Plus HMO D-SNP an objective means to help identify special populations, geographical needs, identify trends and help prioritize opportunities. BlueCare Plus HMO D-SNP 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 bluecareplus.bcbst.com.

L. Integrated Communication Network

BlueCare Plus HMO D-SNP 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 HMO D-SNP members. BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP periodically assesses and evaluates the rate of progression toward goals while identifying and addressing any barriers to meeting the goals. 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 HMO D-SNP 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 are too complex to be solved by one discipline in order to provide for efficient health care. As a health care provider for a BlueCare Plus HMO D-SNP member, you may be asked to participate in an individual member’s ICT. 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 HMO D-SNP will make every effort to have the member participate in his or her ICT, if feasible.

To contact BlueCare Plus HMO D-SNP 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 for 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

BlueCare Plus HMO D-SNP discharge planning and transition of care processes are designed to coordinate proactive discharge planning by assisting members through the transition process and collaborating with providers regarding discharge services.

BlueCare Plus’ goal is for the Care Coordinator to function as an identified point of contact for a member through coordination of transitions to ensure a member understands events that occur throughout the transition process. Our intent is to ensure the member is adherent to the treatment regimen as prescribed by the PCP or other treating providers by staying in touch with the member before, during and after the transition. Additionally, our intent is to assist providers by closely monitoring transitions and services to improve seamless transitions of care across health care settings.

Our transition of care processes were designed based on the Coleman Model of care for managing and ensuring seamless transition of care, CMS’ requirements for managing transitions, and NCQA’s Special Needs Plans Structure and Process Guidelines for transitions.

The Care Coordinator can act as the member’s single point of contact and provide care management support as they move from setting to setting. The Care Coordinator will assist the PCP or other treating providers manage transitions by actively managing the transition of a member from notification through planning and preparing for transitions, coordinating follow-up care and services, and assuring timeliness of services throughout the transition process. Some of the services the Care coordinator can provide include, but are not limited to:

- Remain in touch with the member or caregiver throughout the transition
- Explain each step of the transition process to ensure the member understands activities that are occurring
- Ensure the member has adequate transportation to and from the settings that are being transitioned
- Provide education on planned procedures/services
- Follow-up after the transition should have occurred to confirm the transition occurred as planned
- Ensure the member obtained prescriptions if prescribed
- Contact the treating provider to determine services needed post transition and make arrangements for those services
- Close monitoring after an acute inpatient discharge to prevent readmissions

Although Care Coordinators manage transitions related to other settings, members who are in an acute inpatient setting are closely monitored to evaluate the member’s health status after discharge, identify any health status changes, notify the treating physician of changes, and make arrangements for appropriate services in an effort to prevent readmission. Members are contacted after an acute inpatient admission within 2 business days of discharge to:

- Review discharge instructions
- Determine a member or caregiver's understanding of discharge instructions and services needed, if applicable
- Make arrangements for post discharge services if not already done
- Assist the member or caregiver in scheduling a follow-up physician appointment
- Perform medication reconciliation
- Determine prescriptions were filled or make arrangements to be filled
- Discuss warning signs and triggers
The member or caregiver will be contacted again at 7, 14, 21 and 30 days after discharge.

The following is a checklist of talking points used by the Care Coordinator

<table>
<thead>
<tr>
<th>Discharge Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What were your doctor’s instructions for returning home?</strong></td>
</tr>
<tr>
<td><em>(Let member tell you in their own words)</em></td>
</tr>
<tr>
<td><strong>Do you understand the discharge instructions you were given at the hospital?</strong></td>
</tr>
<tr>
<td><em>(Ask member to read them to you)</em></td>
</tr>
<tr>
<td><strong>Do you have an action plan that your doctor gave you to use when you began to experience worsening symptoms?</strong></td>
</tr>
<tr>
<td><strong>Discuss “warning signs and provide information on when to contact their physician or go to the emergency room.</strong></td>
</tr>
<tr>
<td><strong>Before you went into the hospital this time, did anything specific happen that you think may have caused your symptoms or made them worse?</strong></td>
</tr>
<tr>
<td><em>(e.g. could not get to physician’s office, did not have medical equipment, did not have medication)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication Reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Did you doctor talk to you about any changes in your medicine or prescribe any new medicine?</strong></td>
</tr>
<tr>
<td><strong>If you had prescriptions when you were discharged from the hospital, did you get them filled? If no, why not?</strong></td>
</tr>
<tr>
<td><em>(As appropriate:)</em></td>
</tr>
<tr>
<td>- Coordinate transportation</td>
</tr>
<tr>
<td>- Contact caregiver to assist with getting meds filled</td>
</tr>
<tr>
<td>- Assist member in locating nearest pharmacy</td>
</tr>
<tr>
<td>- Contact MD if member refuses to take medicine</td>
</tr>
<tr>
<td><strong>Do you have any questions about any of your medications?</strong></td>
</tr>
<tr>
<td><strong>What medications were you taking before you went into the hospital?</strong></td>
</tr>
<tr>
<td><strong>What medications are you supposed to be taking now?</strong></td>
</tr>
<tr>
<td><strong>Are you receiving prescriptions from more than one doctor?</strong></td>
</tr>
<tr>
<td><strong>Do you keep a medicine list?</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>- Instruct member to take to every doctor appointment</td>
</tr>
</tbody>
</table>
- Compare list to the list they had before he or she went into the hospital and their list now and discuss any changes

No
- Assist in developing a list

### Are you taking any additional medications other than what your doctor prescribed? Any over the counter medications? Any herbal medications?

### Do you have a hard time remembering when to take your medicine?
As appropriate instruct member to:
- Pre-sort pills into a plastic container such as a pill box
- Use a calendar and write down the times and medications they need to take
- Set visual reminders such as setting medication close to something they deal with every day, for example if medicine is supposed to be taken in the morning set the medicine by your coffee pot, if it’s supposed to be taken at night, set it by your toothbrush
- Write AM or PM with a red pen on each bottle
- Set an auditory reminder, an alarm clock, cell phone, kitchen timer, etc.
- Have a friend or family member remind him or her to take medicine or to ask if he or she has taken your medicine

### Do you know what to do if you miss a dose?
- Instruct member to review the instructions they were given at the pharmacy
- Instruct the member to always ask their doctor what to do if they miss a dose of a newly prescribed medication
- Instruct the member to call their pharmacy

### Follow-up Appointment

Have you made a follow-up appointment with your doctor? You should see your doctor within a week of being discharged from the hospital.
Yes
- What is the date and time of your appointment?
- Do you need us to call and remind you of your appointment?
- Do you have transportation? (if no coordinate with MCO for transportation)
- Do you have any specific questions you want to ask the doctor during your visit (help the member make a list of questions)
- Be sure to take your medications or medicine list to your doctor’s appointment.
- We will call you after your appointment to see if you have any questions.

No
- Do you want me to help you make an appointment?

### What other doctors are you supposed to see after discharge?

### Other

### Is pain management an issue?

### Do you have any outpatient tests scheduled?

### Do you have any outpatient treatment scheduled, such as home health?
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did your doctor order you any medical equipment?</td>
<td></td>
</tr>
<tr>
<td>If yes:</td>
<td></td>
</tr>
<tr>
<td>- Did you receive your equipment?</td>
<td></td>
</tr>
<tr>
<td>Do you need assistance with transportation to any outpatient tests or services?</td>
<td></td>
</tr>
<tr>
<td>Do you have the name and phone number of your doctor?</td>
<td></td>
</tr>
<tr>
<td>Do you have the name and phone number of someone to call if there are problems?</td>
<td></td>
</tr>
<tr>
<td>Do you have my name and phone number?</td>
<td></td>
</tr>
</tbody>
</table>

During transitions of care, a member may also need Medicaid services and if so, the Care Coordinator will coordinate with the Medicaid MCO Care Coordinator to arrange for those services. Additionally, electronic notification is sent to each Medicaid MCO regarding BlueCare Plus HMO D-SNP acute inpatient admissions. Care Coordinators are specifically trained on the Bureau of TennCare’s Long Term Care Program, CHOICES, and nursing facility diversion activities.

### 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.

### 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP has a Nursing Facility Diversion program to help allow BlueCare Plus HMO D-SNP 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 HMO D-SNP adheres to CMS' Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS' Internet Only Medicare Managed Care Manual. CMS' requirements for Medicare Part C vary from the requirements for Original Medicare. Chapter 13 of the Managed Care Manual is a significant resource utilized to implement BlueCare Plus's Utilization Management programs. Utilization management includes services that require prior authorization, services that require notification, advance determinations and retrospective review, requested by a member, practitioner or provider. CMS' Medicare Advantage reconsideration process is available in cases of dissatisfaction with the review decision. Provider reimbursement appeals are handled...
through the CMS mandated Provider Payment Dispute Process. Additional Provider appeals are handled through the BCBST Provider Dispute Resolution Procedure.

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.

The hierarchy of decision is that the service must:

- Be a benefit
- Not be excluded according to CMS National and Local coverage guidelines
- Be Appropriate and Medically Necessary

The hierarchy of references includes:

- The law (Title 18 of the Social Security Administration (SSA));
- The Code of Federal Regulations (Title 42 CFR part 422 and 476);
- Coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), sub manuals Pub 100-04 Claims Processing, Pub 100-02 Benefit Policy Manual, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual;
- National Coverage Determinations;
- Pub 100-03 of the Internet Only Manual); Local Coverage Determinations (http://www.cms.gov/mcd/search.asp);
- Local Coverage Determinations, including Durable Medical Equipment;
- Medicare Administrative Contractor DMEMAC associated Program Safeguard Contractor (PSC);
- Milliman Care Guidelines® or Behavioral Health Guidelines;
- BCBST Modified Utilization Management Guidelines;
- Modified Milliman Care Guidelines® or Modified Behavioral Health Guidelines (http://www.bcbst.com/providers/UM_Guidelines/)
- BCBST Medical Policy;
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC) associated
- Program Safeguard Contractor (PSC) local coverage determinations (LCD)
- Other major payer policy and peer reviewed literature

### B. 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 coverage, Medical Necessity and Appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that were not reviewed prospectively will 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.
C. 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, behavioral health facility, skilled nursing facility, rehabilitation facility inpatient admissions, and substance abuse
- 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
- Psychological Testing
- Home Health Services to include all therapies, nursing visits and psychiatric visits

D. Contact Information

The following information assists in determining the appropriate contact method according to type of service requested:

Utilization Management
Telephone: 1-866-789-6314
Fax: 1-866-325-6698

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 HMO D-SNP 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.

Prior authorizations are approvals in advance for certain services drugs. Covered services that require prior authorization are identified below:

Notification and authorization requests should be submitted to BlueCare Plus HMO D-SNP:

Inpatient Admissions may be requested by telephone 1-866-789-6314
Authorizations may be submitted through BlueAccess
Authorization fax forms are available at
http://bluecareplus.bcbst.com/providerresources/education.html

F. Non-Compliance with Prior Authorization Requirements

Services provided without obtaining approval are considered “non-compliant” when prior authorization is required. Provider must obtain authorization prior to scheduled services. Failure to comply within specified authorization timeframes will result in a contractual denial. BlueCare Plus HMO D-SNP providers cannot bill members for covered services denied due to non-compliance by the provider.

If a member does not inform the provider that he/she has BlueCare Plus HMO D-SNP coverage and the provider discovers that the member does have BlueCare Plus HMO D-SNP coverage, the provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, to the Appeals Department. An appeal will only be overturned if both Medical Necessity is determined and there is clear evidence that the facility was not aware that the member had BlueCare Plus HMO D-SNP coverage at the time services were rendered.

G. Mandated Notices

A. Important Message from Medicare (IM):
Any facility providing care at an inpatient hospital level is responsible for delivering advance written notice of a member’s rights as a hospital inpatient including discharge appeal rights to the member or the authorized member representative in accordance with applicable CMS regulations. CMS requires the Important Message from Medicare (IM) be distributed no later than two (2) calendar days following the member’s admission to the hospital and follow-up notice as far in advance of discharge as possible, but no more than two (2) calendar days before discharge unless the notice is delivered within two (2) calendar days of discharge.

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 HMO D-SNP no longer intends to continue coverage of an authorized hospital inpatient admission. BlueCare Plus HMO D-SNP 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 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.

The NOMNC should be delivered at least two (2) days prior to the member’s HHA, SNF, or CORF 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 HMO D-SNP 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 HMO D-SNP no longer intends to continue coverage. BlueCare Plus HMO D-SNP delegates to providers the responsibility for developing and delivering the DENC for provider discharge determinations and for delivery of the DENC for BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP members that a request for denial notice must be submitted to BlueCare Plus HMO D-SNP by the member, in the event that the member believes that he/she is being denied service.

E. Providing members with notice of their appeal rights – Requirements for Hospitals, SNFs, CORFs, and HHAs
 Hospitals must notify Medicare beneficiaries including Medicare Advantage beneficiaries, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing An Important Message from Medicare (IM), including complying with the time frames for delivery. For copies of the notice and additional information regarding IM notice and delivery requirements, go to Beneficiary Notices Initiative (BNI) Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in plans, about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including complying with the time frames for delivery. For
copies of the notice and the notice instructions, go to Notice of Medicare Non-Coverage. As directed in the instructions, the NOMNC should contain BlueCare Plus HMO D-SNP contact information somewhere on the form (such as in the additional information section on page 2 of the NOMNC). Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities or skilled nursing facilities, must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-coverage) within the time frames specified by law. For copies of the notices and the notice instructions, go to Beneficiary Notices Initiative or Beneficiary Notices Initiative for Medicare Prescription Drug Coverage.

H. Acute Care Facility

In order for the services to be covered under BlueCare Plus HMO D-SNP, care and treatment must be medically necessary and appropriate in an inpatient setting.

- Clinical information needed for processing an advance determination/prior authorization request:
  - Procedure
  - Operation to be performed, if applicable;
  - Diagnosis with supporting signs/symptoms;
  - Treatment Plan;
  - Vital signs and abnormal lab results;
  - Elimination status;
  - Ambulatory status;
  - Hydration status;
  - Comorbidities that impact patient’s condition;
  - Complications;
  - Prognosis or expected length of stay;
  - Current medications

I. Skilled Nursing Facility (SNF)

In order for SNF services to be covered under BlueCare Plus HMO D-SNP, 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 BlueCare Plus HMO D-SNP Skilled Nursing Fax form located online at http://bluecareplus.bcbst.com/provider-resources/education.html and fax to 1-866-789-6314.
BlueCare Plus HMO D-SNP has dedicated clinical Care Coordinators available to assist you with necessary services for your BlueCare Plus HMO D-SNP patients. You may contact our Utilization Management team at 1-866-789-6314

Basic information needed for processing an advance determination or prior authorization 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.

1. Evaluation and Plan of Care
Evaluation of the member must be submitted and include the following as appropriate:
- Primary diagnosis;
- Circulation and sensation;
- Ordering practitioner and date of last visit;
- Gait analysis;
- Date of diagnosis onset;
- Cooperation and comprehension;
- Baseline status;
- Developmental delays (pediatric patients);
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Other therapies or treatments;
- Patient’s goals;
- Strength;
• Medical compliance;
• Range of motion; and
• Support system/Caregiver.

Plan of care must be submitted including the following as appropriate:
• Short and long-term goals;
• Proposed admission date;
• Discharge goals;
• Frequency of treatment;
• Measurable objectives;
• Specific modalities, therapy, exercise;
• Functional objectives;
• Safety and preventive education;
• Home program; and
• Community resources.

K. Services

1. Therapy Services
Therapy services appropriate for Skilled Nursing Facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:
• Complex wound care requiring hydrotherapy; and
• Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

2. Nursing Services
Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:
• Intramuscular injections or intravenous injections or infusions;
• Initiation of and training for care of newly placed:
  o Tracheostomy;
  o In-dwelling catheter with sterile irrigation and replacement;
  o Colostomy;
  o Levin tube;
  o Gastrosomy tube and feedings;
• Complex wound care involving medication application and sterile technique; and
• Treatment of Grade 3 or higher decubitus ulcers or widespread skin disorder.

3. Nursing and Therapy Services Not Requiring SNF Placement:
Skilled nursing facility placement is not necessary for the services listed below. This list is not all inclusive.
• Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
• Custodial services, e.g., non-infected postoperative or chronic conditions;
• Activities or programs primarily social or diversional in nature;
• General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
• Routine care of colostomy or ileostomy;
• Routine services to maintain functioning of in-dwelling catheters;
• Routine care of incontinent patients;
• Routine care in connection with braces and similar devices;
• Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
• Duplicative services - Physical therapy services that are duplicative of occupational therapy services being provided or vice versa;
• Invasive procedures;
• General supervision of aquatic exercise or water-based ambulation;
• Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
• Hot and cold packs applied in the absence of associated modalities;
• Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
• Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

4. Rehabilitation Facility
In order for rehabilitation facility services to be covered under BlueCare Plus HMO D-SNP, care and treatment must be medically necessary and appropriate. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for members both requiring and able to participate in a minimum of 3 hours of daily therapy.

BlueCare Plus HMO D-SNP has dedicated clinical Care Coordinators available to assist with necessary services for your BlueCare Plus HMO D-SNP patients. Our Care Management team can be contacted at 1-877-715-9503.

• Basic information needed for processing an advance determination or prior authorization 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;
• Admission date; and
• Caller’s name.

Clinical Information required for review:
• Admitting diagnosis, symptoms, treatment, frequency of therapies, member’s ability to participate in treatment;
• Member is ventilator dependent or not; and
Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination; and

Discharge plans.

**Evaluation of the Member must be submitted including the following as appropriate:**

- Gait analysis;
- Primary diagnosis;
- Circulation and sensation;
- Date of diagnosis onset;
- Cooperation and comprehension;
- Baseline status;
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Other therapies or treatments;
- Patient’s goals;
- Strength;
- Medical compliance;
- Range of Motion; and
- Support system/Caregiver.

**Plan of care must be submitted including the following as appropriate:**

- Short and long-term goals;
- Proposed admission date;
- Discharge goals;
- Frequency of treatment;
- Measurable objectives;
- Specific modalities, therapy, exercise;
- Functional objectives;
- Safety and preventive education;
- Home program; and
- Community resources.

5. **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 HMO D-SNP, 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 a member’s care.

**Basic information needed for processing an advance determination request:**

- Member’s identification number, name, and date of birth;
Clinical information/documentation required for review is in the sample copy of the BlueCare Plus HMO D-SNP Home Health Fax Form. To facilitate an advance determination or prior authorization request please use the BlueCare Plus HMO D-SNP Home Health Fax form located online at http://bluecareplus.bcbst.com/provider-resources/education.html and fax to 1-866 325-6698.

Providers will be contractually obligated to provide services at the agreed upon rates, regardless of patient acuity or nursing skill level.

In accordance with the National Uniform Billing Committee (NUBC) providers should use type of bill (TOB) 032X for claims filed for home health services. Billing of home health agency visits for therapy or medical social service requires only the appropriate revenue code and billing units. The use of a HCPCS procedure code in billing for these services is optional.

The only supplies that may be billed in addition to home health services are those indicated on the following BlueCare Plus Home Health Agency Non-Routine Supply List:

**The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:**

A4212 A4331 A4357 A4375 A4390 A4407 A4422 A4455 A5057 A5112 A7508 T4523 T4540
A4248 A4333 A4358 A4376 A4391 A4408 A4423 A4456 A5061 A5113 A7509 T4524 T4541
A4310 A4334 A4360 A4377 A4392 A4409 A4424 A4461 A5120 A5114 A7520 T4525 T4542
A4311 A4338 A4361 A4378 A4393 A4410 A4425 A4463 A5062 A5121 A7521 T4526 T4543
A4312 A4340 A4362 A4379 A4394 A4411 A4426 A4481 A5063 A5122 A7522 T4527
A4313 A4344 A4363 A4380 A4395 A4412 A4427 A4623 A5071 A5126 A7523 T4528
A4314 A4346 A4364 A4381 A4396 A4413 A4428 A4625 A5072 A5131 A7045 T4529
A4315 A4349 A4366 A4382 A4397 A4414 A4429 A4626 A5073 A7501 A7524 T4530
A4316 A4351 A4367 A4383 A4398 A4415 A4430 A5051 A5081 A7502 A7526 T4531
A4320 A4352 A4368 A4384 A4399 A4416 A4431 A5052 A5082 A7503 A7527 T4532
A4321 A4353 A4369 A4385 A4400 A4417 A4432 A5053 A5083 A7504 S8185 T4533
A4326 A4354 A4371 A4387 A4404 A4418 A4433 A5054 A5093 A7505 S8210 T4534
A4328 A4355 A4372 A4388 A4405 A4419 A4434 A5055 A5102 A7506 T4521 T4535
A4330 A4356 A4373 A4389 A4406 A4420 A4435 A5056 A5105 A7507 T4522 T4537

The following codes should be used when billing Home Health Agency Non-Routine Supplies

A6010 A6204 A6220 A6236 A6251 A6404 A6450
A6011 A6205 A6221 A6237 A6252 A6407 A6451
A6020 A6206 A6222 A6238 A6253 A6410 A6452
A6021 A6207 A6223 A6239 A6254 A6412 A6453
A6022 A6208 A6224 A6240 A6255 A6441 A6454
A6023 A6209 A6228 A6241 A6256 A6442 A6455
A6024 A6210 A6229 A6242 A6258 A6443 A6456
A6154 A6211 A6230 A6243 A6259 A6444 A6457
Supplies on the BlueCare Plus 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. Reimbursement for supplies used in conjunction with the above services will be limited to those indicated on the BlueCare Plus Home Health Agency Non-Routine Supply List located in the BlueCare Plus Provider Administration Manual.

Reimbursement for supplies not indicated on the BlueCare Plus Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health visit and will not be reimbursed separately.

Reimbursement for supplies billed by the Home Health Agency that are not used in conjunction with the above services will be $0.00.

6. Durable Medical Equipment (DME)
Basic information needed for processing an advance determination or prior authorization request:
- Member’s identification number and name;
- 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;
- Member’s diagnosis and expected prognosis;
- Copy of certificate of medical necessity and signed prescription;
- Estimated duration of use;

Limitations and capability of the member to use the equipment; itemization of the equipment components, if applicable; appropriate HCPCS codes for equipment being requested; and member’s weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

7. Speech, Occupational and Physical Therapy
In order for therapy services to be considered for benefits, the services must be medically necessary and medically appropriate to the treatment of the member’s illness or injury.

- Basic information needed for processing an advance determination or prior authorization 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:
• Assessment Requirements (Evaluation and Plan of Care) Evaluation;
• Ordering practitioner and date of last visit;
• Primary diagnosis;
• Date of diagnosis onset;
• Baseline status/current abilities;
• Functional potential;
• Prior level of functioning;
• Current functional abilities;
• Functional potential;
• Expected maximum level of functioning;
• Strength, ROM, if applicable;
• Circulation and sensation;
• Cooperation and comprehension;
• Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders;
• Support system/caregiver;
• Other therapies or treatments;
• Patient's goals; and
• Therapy compliance.

Plan of Care
• Long and short-term goals;
• Discharge goals;
• Measurable objectives;
• Functional objectives;
• Home program, if applicable;
• Duration of therapy;
• Frequency of therapy;
• Date therapy is to begin;
• Specific therapy techniques;
• Safety and preventive education; and
• Community resources.

8. Orthotics/Prosthetics
Basic information needed for processing an advance determination or prior authorization 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:

- Member's diagnosis and expected prognosis;
- Limitations and capability of the member to use the equipment;
- Itemization of the equipment components, if applicable; and
- Appropriate HCPCS codes for equipment being requested.

9. Specialty Pharmacy (Part B Drugs)
In order for Part B drugs to be considered for benefits, the service must be medically necessary and medically appropriate to the treatment of the member’s illness or injury according to National Coverage Determinations and/or Local Coverage Determinations. Certain Part B Specialty Pharmacy medications require prior authorization.

10. Organization Determinations
An organization determination is a determination of Medical Necessity and Appropriateness related to payment of services. Organization determinations include prior authorizations, advance determinations and retrospective reviews. An organization determination for an advance determination request will be reviewed as expeditiously as the member’s health condition requires, but no later than fourteen (14) Calendar days after the date of receipt of request for a Standard Organization Determination. An expedited organization determination will be performed when requested or supported by a physician indicating that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member’s ability to regain maximum function. Additionally, the physician does not need to be appointed as the member’s authorized representative in order to make this request. BlueCare Plus HMO D-SNP will render a decision as expeditiously as the member’s health condition requires, but no later than Seventy-two (72) hours after receiving the request for expedited review. BlueCare Plus HMO D-SNP will extend the 72-hour time frame by up to fourteen (14) Calendar days if the member requests the extension or if BlueCare Plus HMO D-SNP justifies a need for additional information and documents how the delay is in the interest of the member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that a member has already received.

Retrospective reviews are completed within thirty (30) Calendar days of receipt of the request for a Standard Organization Determination.

11. Advanced Imaging
Prior authorization is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization is not required for imaging procedures performed during an inpatient admission or emergency room visit. Procedures requiring prior authorization include, but are not limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Positron emission tomography (PET)
- Nuclear cardiology
12. Bone Density/CT Bone Density Exclusions from Advanced Imaging Program

*Bone Mass Measurements are for the purpose of establishing the diagnosis of osteoporosis and to assess the individual’s risk for subsequent fracture and are excluded from this requirement. These measurements are considered part of Medicare’s Preventive Services. To request prior authorization for any of the above listed radiology procedures, call MedSolutions, Inc., at 1-800-467-6424 or 1-800-575-4594.

13. Retrospective Claims and Clinical Record Review

Retrospective claims reviews may be conducted to provide a determination of Medical Necessity, as well as verification of eligibility and benefits. Claims are targeted for review based on National Coverage Determinations, Local Coverage Determinations and BCBST Medical Policy. Reviews are performed prior to claims payment using CMS’ processing guidelines (i.e. post acute care transfer policy, low utilization payment adjustments, outlier payments, etc.).

Retrospective clinical record reviews may be conducted to meet our CMS contractual requirements. Record review results support CMS and other regulatory agencies audits, applicable accreditation audits, quality improvement activities, Quality Improvement Organization (QIO) and Independent Review Entity (IRE) review processes, and CMS’ risk-adjusted payment processes.

Utilization Management Contact Information:

Phone: 1-866-789-6314
Fax: 1-866 325-6698

Mailing Address:

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

14. Reconsideration Process

A Standard Reconsideration of an adverse organization determination or termination of services decision may be requested by a member or member’s authorized representative. A physician may be appointed to act as a member’s representative and file an appeal on his or her behalf. Both the member and practitioner must sign, date and complete a representation form. CMS-1696 Appointment of Representation form is located on the CMS website at http://www.cms.gov/cmsforms/downloads/cms1696.pdf.

A written request for a Standard Reconsideration must be submitted within sixty (60) calendar days from the date of the notice of the organization determination. Send Reconsideration requests to:

BlueCare Plus HMO D-SNP Member Appeals
1 Cameron Hill Circle, Ste 0042
Chattanooga, TN 37402-0039
A Standard Reconsideration of the denial of a request for service will be determined no later than thirty (30) calendar days from the date the request of a Standard Reconsideration is received. The timeframe may be extended up to 14 calendar days at the member’s request.

A member or physician may submit a verbal or written request for an Expedited Reconsideration in situations where applying the standard of procedure could seriously jeopardize the member’s life, health, or ability to regain maximum function. If BlueCare Plus HMO D-SNP approves a request for an Expedited Reconsideration, the review will be completed no later than seventy-two (72) hours after receiving the request. The seventy-two (72)-hour timeframe may be extended up to fourteen (14) calendar days at the member’s request for an extension. A request for payment of a service already provided to the member is not eligible to be reviewed as an Expedited Reconsideration.

15. 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).

16. Utilization Management Forms
The Utilization Management forms are also available on the

17. Observation Notification
Participating providers are responsible for notifying the UM Department of observation stays. Members or their representatives may also notify his or her Care Coordinator of an observation stay; however, as a participating provider, you are responsible for providing observation notification. Observation notifications may be submitted by telephone, fax (using the observation notification fax form for your convenience), or through web authorization. The purpose of notification is to quickly initiate necessary care coordination activities or assist with transitioning the member to another setting.

The attached fax form needs to be placed in the section with the other fax forms
Observation Notification Fax Form
BlueCare Plus (HMO SNP)™
Observation Notification Fax Form

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number</td>
<td></td>
</tr>
<tr>
<td>Date of Admission to Facility</td>
<td></td>
</tr>
<tr>
<td>Facility Name</td>
<td></td>
</tr>
<tr>
<td>Facility Telephone Number</td>
<td></td>
</tr>
<tr>
<td>Facility Address</td>
<td></td>
</tr>
<tr>
<td>NPI Number</td>
<td>Tax ID# (the last 5 digits)</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Phone</td>
</tr>
<tr>
<td>Requesting Physician</td>
<td>NPI Number</td>
</tr>
<tr>
<td>Requesting Physician Provider #</td>
<td>Tax ID# (the last 5 digits)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td></td>
</tr>
<tr>
<td>CPT® Code</td>
<td>ICD9 Code</td>
</tr>
</tbody>
</table>

All Non-Urgent or Non-Emergent Out-of-Network Services require prior authorization.

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.

H3259_15_UMObservationfax 8/2014
A. General Fax Form

BlueCare Plus
Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-2001
bluecareplus.bcbst.com

This Information is:
☐ Public ☐ Internal (BlueCross BlueShield of Tennessee Use Only) ☐ Confidential ☐ Highly Confidential

Date: ______________

To: ____________________
From: ____________________

Company: ____________________
Company: ____________________

Fax: ____________________
Fax: ____________________

Phone: ____________________
Phone: ____________________

Number of Pages (Including Cover):

Comments:

This facsimile may contain privileged information intended only for use by the specific individual or entity named above. If you or your employer are not the intended recipient of the facsimile or an agent responsible for delivering it to the intended recipient, you are hereby notified that any unauthorized distribution or copying of this facsimile or the information contained in it, is strictly prohibited. If you have received this facsimile in error, please immediately notify the person named above by telephone. You may destroy or return the original facsimile to the above address via the U.S. Postal Service. Thank You.

BlueCare Plus Tennessee, an independent licensee of the BlueCross BlueShield Association. BlueCare Plus Tennessee is a Health plan with a Medicare contract and a contract with the Tennessee Medicaid Program.

Y0013_W14_P2
B. Advance Determination Decision Fax

BlueCare Plus (HMO SNP) Utilization Management
Advance Determination Decision
Telephone Number: 1-866-781-3489
Fax: 1-866-325-6698

Date: ____________________ Reference Number: ____________________

To: [Fax number] Contact Name: [Contact name]

Your request for an advance determination for:
Member Name: ____________________ ID Number: ____________________

Type of Service ____________________ has been received and reviewed. The following decision has been made:

| Date(s) of Service APPROVED: | ____________ TO: ____________ |
| Procedures (if applicable): |

| Date(s) of Service DENIED: | ____________ TO: ____________ |
| Reason for Denial: |
| Procedures (if applicable): |

Note: Organization determination is subject to verification of all medical information and is valid only if such information is accurate and complete. If you render services and choose not to accept assignment from the Original Medicare Plan, you may not exceed the Medicare Limiting Charge. The member will be financially liable for these excess charges.

This benefit determination was made in accordance with 42 CFR Part 410.

This facsimile contains privileged and confidential information intended only for use of the specific individual or entity named above. If you or your employer are not the intended recipient of this facsimile (or an agent responsible for delivering it to the intended recipient), you are hereby notified that any unauthorized distribution or copying of this facsimile or the information contained in it is strictly prohibited. If you have received this facsimile in error, please immediately notify the person named above by telephone and return the original facsimile to the above address via the U.S. Postal Service.

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association
BlueCare Plus is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid Program.
Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.
C. Advance Determination Request Fax

BlueCare Plus (HMO SNP)™
Advance Determination Request
Fax Form

Member Name ___________________________ DOB ___________________________
Member ID Number ___________________________
Procedure/Service Requesting ___________________________ CPT® Code ___________________________
Diagnosis ___________________________ ICD9 Code ___________________________
Co-morbidities ___________________________
Plan of Treatment ___________________________

Facility/Provider Name ___________________________ Facility/Provider# ___________________________
Address ___________________________ NPI ___________________________
Tax ID# (the last 5 digits) ___________________________ Contact Person ___________________________
Phone Number ___________________________ Fax Number ___________________________
Requesting Physician ___________________________ Phone ___________________________
Requesting Physician Provider Number ___________________________
NPI Number ___________________________ Tax ID# (the last 5 digits) ___________________________

Telephone Number 1-866-781-3489
Fax 1-866-325-6698

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association
BlueCare Plus is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid Program.
Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.

H3259_13_UMadvdeterreqfax
D. Authorization Decision Fax

BlueCare Plus (HMO SNF)™
Utilization Management
Authorization Decision
Telephone Number: 1-866-781-3489
Fax: 1-866-325-6698

Date: _______________ Reference Number: _______________

To: [Fax number] Contact Name: [Contact name]

Your request for authorization for:

Member Name: _______________ ID Number: _______________

Type of Service: __________________________

has been received and reviewed. The following decision has been made:

<table>
<thead>
<tr>
<th>Date(s) of Service APPROVED:</th>
<th>TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures (if applicable):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date(s) of Service DENIED:</th>
<th>TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for Denial:</td>
<td></td>
</tr>
<tr>
<td>Procedures (if applicable):</td>
<td></td>
</tr>
</tbody>
</table>

Note: Organization determination is subject to verification of all medical information and is valid only if such information is accurate and complete. If services are received out-of-network, the member’s benefits may be reduced. This benefit determination was made in accordance with 42 CFR Part 410.

This facsimile contains privileged and confidential information intended only for use of the specific individual or entity named above. If you or your employee are not the intended recipient of this facsimile (or an agent responsible for delivering it to the intended recipient), you are hereby notified that any unauthorized distribution or copying of this facsimile or the information contained in it, is strictly prohibited. If you have received this facsimile in error, please immediately notify the person named above by telephone and return the original facsimile to the above address via the U.S. Postal Service.

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Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.

H3259_13_UMAuthdecfax
## E. Durable Medical Equipment (DME) Request Fax

**BlueCare Plus (HMO SNP)**

**DME Request Fax Form**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Name</td>
<td>DOB</td>
</tr>
<tr>
<td>Member ID Number</td>
<td>LPPO PFFS</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ICD9 Code</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td></td>
</tr>
<tr>
<td>Symptoms</td>
<td></td>
</tr>
<tr>
<td>Surgery Type</td>
<td>Surgery Date</td>
</tr>
<tr>
<td>PO2 level</td>
<td>O2 Sat</td>
</tr>
<tr>
<td>Arterial blood gas results</td>
<td>Date Drawn</td>
</tr>
<tr>
<td>Beginning Date of Service</td>
<td>Date of Services Requested</td>
</tr>
<tr>
<td>Equipment Requested</td>
<td></td>
</tr>
<tr>
<td>Information Needed To Complete Evaluation</td>
<td></td>
</tr>
<tr>
<td>&gt;HCPCS code for items requested</td>
<td></td>
</tr>
<tr>
<td>&gt;Rental or Purchase</td>
<td></td>
</tr>
<tr>
<td>&gt;Cost of items requested</td>
<td></td>
</tr>
<tr>
<td>&gt;Certificate of Medical Necessity (if applicable to CMS guidelines)</td>
<td></td>
</tr>
<tr>
<td>Supplier</td>
<td>Phone Number</td>
</tr>
<tr>
<td>Requesting Physician</td>
<td>Provider#</td>
</tr>
<tr>
<td>NPI Number</td>
<td>Tax ID# (the last 5 digits)</td>
</tr>
<tr>
<td>Phone Number</td>
<td>Fax Number</td>
</tr>
<tr>
<td>Address</td>
<td>Contact Person</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>1-866-781-3489</td>
</tr>
<tr>
<td>Fax</td>
<td>1-866-325-6698</td>
</tr>
</tbody>
</table>

---

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

BlueCare Plus is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid Program.

Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.

H3259_13_Umdmerefax
F. Home Health Request Fax

BlueCare Plus (HMO SNP)™
Home Health Request Fax Form

Member Name ___________________________ DOB ___________________________
Member ID Number ____________________ PFFS ________ LPPO ________
Diagnosis ___________________________ ICD-9 Code ________
Co-Morbidities ___________________________
Surgery Procedure ___________________________ Surgery Date __________
Service(s) requested ___________________________ Number of visits requested __________

Please answer or attach the following items as applicable:

Is member homebound? Yes____No____
Homebound reason ___________________________
Please indicate if an Oasis and 485 are on file: Yes____No____
Do you have physician order? Yes____No____ (please attach)
Frequency and duration ___________________________
Date of the initial evaluation ___________________________
Dates of service requesting ___________________________
Assessment with clinical findings to include measurements and physical impairments:
Treatment Plan ___________________________

Home Health Therapy: Short Term and Long Term Goals ___________________________

Home Health Therapy Extension: Is patient compliant with HEP? Yes____No____
If no, list barriers ___________________________

Skilled Nursing Visit (SNV): Reason for SNV (i.e. assessment, wound care, teaching, home infusion, etc.) Please be specific: ___________________________

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H3259_13_UMhhfax
G. Home Infusion Therapy HIT Request Fax

BlueCare Plus (HMO SNP)

Home Infusion Therapy (HIT) Request Fax Form

<table>
<thead>
<tr>
<th>Member Name (First, Middle, Last)</th>
<th>Member ID Number</th>
<th>Member Date of Birth</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address (Street, City, State, Zip)</th>
<th>Gender</th>
<th>Primary Insurance Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Male</td>
<td>☐ Medicare ☐ PFFS</td>
</tr>
<tr>
<td></td>
<td>☐ Female</td>
<td>☐ LPPO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Member Information</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>HIT Related Diagnosis</th>
<th>Other Diagnosis</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Supportive Documentation Attached:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Signed Doctor’s Orders</td>
</tr>
<tr>
<td>☐ Clinical History</td>
</tr>
<tr>
<td>☐ Culture &amp; Sensitivity</td>
</tr>
<tr>
<td>☐ Misc. Lab</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Justification for Home Infusion Therapy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From: ____________________ To: __________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of HIT Therapy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ IV Hydration ☐ TPN</td>
</tr>
<tr>
<td>☐ IV Drug Administration ☐ PO</td>
</tr>
<tr>
<td>☐ Aerosol ☐ Chemotherapy ☐ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daily Administration Schedule for this Infusion Therapy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuous? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Pump Required? ☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is patient receiving private duty nursing?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is patient receiving any skilled nursing services in addition to home infusion?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous Service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reference #</th>
<th>Date of last Service:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Drug/Supplement with Dosage and Frequency requires NDC Number</th>
<th>Route of Administration</th>
<th>Total Units Requested</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>IV</td>
<td>IM</td>
</tr>
</tbody>
</table>

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

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

H3259_13_Umhitfax
**H. Inpatient Rehabilitation Request Fax**

### BlueCare Plus

Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402-5001
bluecareplus.bcbst.com

---

**BlueCare Plus™**

Inpatient Rehabilitation Request Fax Form

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number</td>
<td>PFS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Admission to Facility</th>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Telephone Number</td>
<td>Facility Address</td>
</tr>
<tr>
<td>NPI Number</td>
<td>Tax ID# (the last 5 digits)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Person</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Requesting Physician</th>
<th>NPI Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requesting Physician Provider #</td>
<td>Tax ID# (the last 5 digits)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>CPT® Code</th>
<th>ICD9 Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height</td>
<td>Weight</td>
<td></td>
</tr>
</tbody>
</table>

**Medications:**

<table>
<thead>
<tr>
<th>Co morbidity</th>
</tr>
</thead>
</table>

**H&P (Attach):**

**Current Lab Values: (e.g., Hemoglobin & Hematocrit), INR, PTT:**

---

Has a Doppler study of the lower extremities been performed? Yes ( ) No ( )

**Patient Level of Orientation**

**Rancho level:** Alert and Oriented ( ) Willing and Able to Participate ( ) Can Follow Commands

**Type of Discipline** ( ) Therapy ( ) Speech ( ) Occupational ( ) Physical

**Number of Hours per Day**

**Type of Surgery:**

Date:

---

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

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H3259_13_UMinpatrehfax

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Y0013_W14_P2 Page 130
# BlueCare Plus (HMO SNP)

## Medical and Psychiatric Inpatient Request Fax Form

<table>
<thead>
<tr>
<th>Member Name</th>
<th>DOB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID Number</td>
<td>PFFS</td>
</tr>
<tr>
<td>Date of admission</td>
<td>Observation: Yes</td>
</tr>
<tr>
<td>Facility/Provider Name</td>
<td>Facility/Provider Number</td>
</tr>
<tr>
<td>NPI Number</td>
<td>Facility Tax ID (last 5 digits)</td>
</tr>
<tr>
<td>Contact person</td>
<td></td>
</tr>
<tr>
<td>Facility Telephone Number</td>
<td>Fax Number</td>
</tr>
<tr>
<td>Requesting Physician</td>
<td>NPI</td>
</tr>
<tr>
<td>Requesting Physician Provider Number</td>
<td>Tax ID# (last 5 digits)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ICD9 Code</td>
</tr>
<tr>
<td>Co-morbidities</td>
<td></td>
</tr>
<tr>
<td>Plan of Treatment</td>
<td></td>
</tr>
<tr>
<td>H/P</td>
<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
</tr>
<tr>
<td>Lab Values</td>
<td></td>
</tr>
<tr>
<td>Is there any Behavioral Health/Case Management or Discharge Plan Needs: Yes</td>
<td>No</td>
</tr>
<tr>
<td>Test Procedures/Results</td>
<td></td>
</tr>
<tr>
<td>Discharge Plans/Goals</td>
<td></td>
</tr>
</tbody>
</table>

**Telephone Number**: 1-866-781-3489  
**Fax**: 1-866-325-6698

---

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association  
BlueCare Plus is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid Program.  
Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.

---

H3259_13_Ummedpsynpatfax
J. Outpatient Therapy Request Fax

BlueCare Plus (HMO SNP)
Outpatient Therapy Request Fax Form

Member Name ___________________________ DOB ___________________________
Member ID Number ____________________ PFFS ________ LPPO ________________
Diagnosis ___________________________ ICD9 Code __________________________
Surgery Procedure ____________________ Surgery Date ________________________
Service(s) requested __________________ Number of visits requested __________

Dates of service(s) or Home Health Certification period ________________________
Please attach the following items as applicable:
- OASIS (Home Therapy)
- 485 (Home Therapy) and Physician Order
- Physical Impairments
- Evaluation and Notes
- Short Term and Long Term Goals
- Treatment Plan

Extension: Is patient compliant with HEP? Yes __________ No __________
If no, list barriers: ______________________________________________________

Facility/Agency Name __________________________ Address ______________________
Facility/Agency Provider Number __________________________

NPI Number __________ Tax ID (last 5 digits) __________________________
Phone __________________ Fax __________________
Contact Person __________________________
Requesting Physician __________________________ Provider Number __________

NPI Number __________________________ Tax ID# (last 5 digits) __________________
Phone __________________ Fax __________________

Telephone 1-866-781-3489
Fax 1-866-325-6698

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association
BlueCare Plus is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid Program.
Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.

H3259_13_UMopattherapyfax
BlueCare Plus (HMO SNP)™
Part B Specialty Pharmacy Drug Request Fax Form

Member Name_____________________________DOB________________
Member ID Number________________________PFFS_________LPPO_________
Name of Drug______________________________
Dosage/Route______________________________
Diagnosis________________________________
Co-morbidities_____________________________
Plan of Treatment/Cycle________________________
Prior Treatments/Medications and Results______________________________
Current Lab Values___________________________
__________________________________________
Date of Service_________________________Place of Service_________________________
Facility/Provider Name______________________Facility/Provider Number________________
NPI Number________________________Tax ID# (last 5 digits)____________
Phone Number ( )____________________Fax Number ( )_____________________
Contact Person______________________________
Requesting Physician________________________Tax ID# (last 5 digits)____________
Requesting Physician Provider Number___________________NPI________________

Telephone Number 1-866-781-3489
Fax 1-866-325-6698

BlueCare Plus Tennessee, an Independent Licensee of the BlueCross BlueShield Association
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H3259_13_Umpartbdrugfax
L. Request for Out-of-Network Benefits Fax

Request for Out-of-Network Benefits

Extension of Service: yes □ no □

Referral #: __________________________
Member Name: ______________________ Member ID#: __________________ D/O/B: ______

Primary Care Practitioner (PCP)

Referring Practitioner Name: __________________ Provider ID #/NPI #: __________
Specialty: __________________ Telephone #: __________ Fax: __________

Non-Participating Practitioner or Facility

Non-participating Practitioner/Facility Name: __________________________
Provider ID #/NPI # and Tax ID# (MUST BE INCLUDED): __________________________
Specialty: __________________ Telephone #: __________ Fax: __________
Provider Address (street): __________________________ (City) __________ (County) __________ (ST) __________ (ZIP) __________

***PROVIDER MUST BE WILLING TO ACCEPT RATES FOR BLUECARE PLUS (HMO SNP)***

Hospital Name for outpatient, 23-hour or inpatient services: __________________________
Address: __________________________

If another Practitioner in the group or on-call Practitioner sees this Member instead of the original requested specialist, that information would need to be submitted via the Out-of-Network Benefit fax form. The information submitted on claim must match the information in the BlueCross BlueShield of Tennessee system.

Member’s Medical Information

*** Attach related records for services to be rendered ***

Symptoms/Diagnoses (Use the most appropriate ICD-9 Codes): __________________________
Service/Procedures to be provided (Use the most appropriate CDT, CPT or HCPCS Codes): __________________________
☐ Office/Follow-Up Visit ☐ Inpatient ☐ Outpatient Procedure ☐ 23-Hour Observation
☐ Behavioral Health ☐ Date(s) of Service:_________ ☐ Emergency Room ☐ Dialysis
☐ Other: Explain __________________________
Frequency/Duration of Services Requested (i.e., 2 times per week for 6 weeks): __________

BlueCross BlueShield of Tennessee, an Independent Licensee of the BlueCross BlueShield Association

BlueCare Plus is an HMO SNP plan with a Medicare contract and a contract with the Tennessee Medicaid Program.
Enrollment in BlueCare Plus (HMO SNP) depends on contract renewal.
M. Transition of Care Fax

BlueCare Plus (HMO SNP)
Notification of Recent Transition
Fax Form
Telephone 1-866-781-3489 Fax 1-866-325-6698

Member Name ___________________________ DOB ___________________________
Member ID Number ___________________________

Is there a change in the Member’s Health Status? □ Yes □ No
If yes, please explain ________________________________________________

Sending Practitioner and/or Facility Information
Sending Facility/Provider Name ___________________________ Facility/Provider#
Address ___________________________________________ NPI _________________
Tax ID# (the last 5 digits) ___________________________ Contact Person _____________
Phone Number ___________________________ Fax Number ___________________________
Discharge plans from sending facility and/or Provider ___________________________

Receiving Practitioner and/or Facility Information
Receiving Facility/Provider Name ___________________________ Facility/Provider#
Address ___________________________________________ NPI _________________
Tax ID# (the last 5 digits) ___________________________ Contact Person _____________
Phone Number ___________________________ Fax Number ___________________________
MCO requested DCP coordination? □ Yes □ No
If Yes Chosen to DCP coordination, please explain ___________________________________________
Requested DCP coordination with MCO? □ Yes □ No
If Yes Chosen to MCO coordination, please explain ___________________________________________

Please Note: BlueCare Plus care management services are provided to members when they move from setting to setting, practitioner to practitioner, and practitioner to facility.

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.

H3259_13_transitionfax
XI. Billing

A. Overview

BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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. Additional companion documents needed for BlueCare Plus HMO D-SNP 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:

Technical Support
call: 423-535-5717
fax: 423-535-3334
e-mail: www.ecomm_support@bcbst.com
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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP member. BlueCare Plus HMO D-SNP will process in the normal course of its business all claims submitted by the Physician/Supplier.

BlueCare Plus HMO D-SNP generates the 277 Health Care Information Status Notification report as proof of timely filing for electronically submitted BlueCare Plus HMO D-SNP 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](#).

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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP. 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="CMS 1500 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>1a</td>
<td>Enter the BlueCare Plus member identification number (required)</td>
<td><img src="image1" alt="Image" /></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="image2" alt="Image" /></td>
</tr>
<tr>
<td>3</td>
<td>Enter the patient’s birth date in the following format; MMDDCCYY and sex</td>
<td><img src="image3" alt="Image" /></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 same enter the word SAME.</td>
<td><img src="image4" alt="Image" /></td>
</tr>
<tr>
<td>5</td>
<td>Enter the BlueCare Plus patient’s mailing address, city, zip and telephone number (required)</td>
<td><img src="image5" alt="Image" /></td>
</tr>
<tr>
<td>6</td>
<td>When item 4 is completed check appropriate box (conditional)</td>
<td><img src="image6" alt="Image" /></td>
</tr>
<tr>
<td>7</td>
<td>Enter insured’s address and telephone if the same as patient enter SAME (conditional)</td>
<td><img src="image7" 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>8</td>
<td>Check appropriate box for marital status, employed or student</td>
<td><img src="image" alt="Patient Status" /></td>
</tr>
<tr>
<td>9</td>
<td>This field may be used in the future for supplemental insurance plans.</td>
<td><img src="image" alt="Patient Status" /></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</td>
<td>(conditional)</td>
</tr>
<tr>
<td>10a-c</td>
<td>Check &quot;YES&quot; 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="Patient Status" /></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="Insurance Plan Name" /></td>
</tr>
<tr>
<td>11</td>
<td>Provider/Supplier made good faith effort to determine who is the primary payer&lt;br&gt;(required)</td>
<td><img src="image" alt="Insured’s Policy Group or PECA Number" /></td>
</tr>
<tr>
<td>11a-c</td>
<td>Additional information only if there is other insurance</td>
<td><img src="image" alt="Insurance Plan Name" /></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>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></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></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></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></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></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></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</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>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>(MMDDYY or MMDDCCYY)</td>
</tr>
<tr>
<td>20</td>
<td>Complete when billing for diagnostic tests subject to anti-markup payment limitation</td>
<td><img src="image" alt="Outside Lab" /></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><img src="image" alt="Diagnosis or Nature of Illness or Injury" /></td>
</tr>
<tr>
<td>22</td>
<td>Leave blank</td>
<td><img src="image" alt="Prior Authorization Number" /></td>
</tr>
<tr>
<td>23</td>
<td>Enter Quality Improvement Organization (QIO) prior authorization number for procedures requiring QIO prior approval</td>
<td><img src="image" alt="Diagnosis Pointer" /></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><img src="image" alt="Date of Service" /></td>
</tr>
<tr>
<td>24a</td>
<td>Date for each procedure, service, or supply MMDDCCYY format</td>
<td><img src="image" alt="Date of Service" /></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>24b</td>
<td>Enter appropriate place of service code(s) for each item used or service performed</td>
<td><img src="image" alt="B. Place of Service" /></td>
</tr>
<tr>
<td>24c</td>
<td>Not required</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="image" alt="D. Procedures, Services, or Supplies" /></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="image" alt="E. Diagnosis Pointer" /></td>
</tr>
<tr>
<td>24f</td>
<td>Enter the charge for each listed service</td>
<td><img src="image" alt="F. Charges" /></td>
</tr>
<tr>
<td>24g</td>
<td>Enter the number of days or units</td>
<td><img src="image" alt="G. Days or Units" /></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="image" alt="I. ID. Qual" /></td>
</tr>
<tr>
<td>24j</td>
<td>Rendering provider’s NPI number</td>
<td><img src="image" alt="J. Rendering Provider ID. #" /></td>
</tr>
<tr>
<td>25</td>
<td>Enter Federal Tax ID (Employer Identification Number or Social Security Number)</td>
<td><img src="image" alt="25. Federal Tax ID. Number" /></td>
</tr>
<tr>
<td>26</td>
<td>Enter patient’s account number assigned by provider of service</td>
<td><img src="image" alt="26. Patient’s Account No." /></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>27</td>
<td>Check block to indicate if supplier accepts assignment of Medicare benefits</td>
<td>![Image of CMS 1500 form example for Item 27]</td>
</tr>
<tr>
<td>28</td>
<td>Enter total charges for services</td>
<td>![Image of CMS 1500 form example for Item 28]</td>
</tr>
<tr>
<td>29</td>
<td>Enter total amount patient paid on covered services only if applicable</td>
<td>![Image of CMS 1500 form example for Item 29]</td>
</tr>
<tr>
<td>30</td>
<td>Leave blank, not required</td>
<td>![Image of CMS 1500 form example for Item 30]</td>
</tr>
<tr>
<td>31</td>
<td>Enter signature of provider of service and date the form was signed (MMDDYY or MMDDCCYY)</td>
<td>![Image of CMS 1500 form example for Item 31]</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>![Image of CMS 1500 form example for Item 32]</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>![Image of CMS 1500 form example for Item 33]</td>
</tr>
</tbody>
</table>
Figure 10 NUCC 02/12 1500 Form (Sample only not for use)
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.

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 include 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.

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>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. C-TRL #</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>3b</td>
<td>Medical/Health Record Number assigned to patient’s medical/health record</td>
<td>B MED. REC.</td>
</tr>
<tr>
<td>4</td>
<td>Four-digit alphanumeric code gives three specific pieces of information</td>
<td>4 TYPE OF BILL</td>
</tr>
<tr>
<td></td>
<td>after a leading zero (required). Code structure available in the Internet</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only Manuals</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax ID (required)</td>
<td>5 FED. TAX NO.</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period (the from and through dates (required)) MMDDYY</td>
<td>8 STATEMENT COVERS PERIOD FROM THROUGH</td>
</tr>
<tr>
<td></td>
<td>format.</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>
</tbody>
</table>

D-SNP
<table>
<thead>
<tr>
<th>Form Location</th>
<th>Description</th>
<th>UB 04 Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>Admission or start of care date (required)</td>
<td>12 DATE</td>
</tr>
<tr>
<td>13</td>
<td>Admission hour (not required)</td>
<td>12 DATE</td>
</tr>
<tr>
<td>14</td>
<td>Priority (type) of admission or visit (required) Codes also available from</td>
<td>12 DATE</td>
</tr>
<tr>
<td></td>
<td>the NUBC via the NUBC’s Official UB-04 Data Specifications Manual.</td>
<td>13 HR 14 TYPE 15 SRC</td>
</tr>
<tr>
<td>15</td>
<td>Point of origin for admission or visit (required)</td>
<td>12 DATE</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>18 - 28</td>
<td>Enter corresponding code to describe any condition or event that may apply</td>
<td>18 19 20 21 22 23 24 25 26 27 28</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>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>39-41</td>
<td>Value Codes and Amounts (required)</td>
<td></td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code (required)</td>
<td>42 REV. CD.</td>
</tr>
<tr>
<td>43</td>
<td>Revenue Description (not required)</td>
<td>43 DESCRIPTION</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rates/HIPP S Rate Codes (required)</td>
<td>44 HCPCS / RATE / HIPP S CODE</td>
</tr>
<tr>
<td>45</td>
<td>Service Date for services (required)</td>
<td>45 SER. DATE</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>46</td>
<td>Units of Service (required)</td>
<td>46 SERV. UNITS</td>
</tr>
<tr>
<td>47</td>
<td>Total Charges (Not applicable for electronic billers)</td>
<td>47 TOTAL CHARGES</td>
</tr>
<tr>
<td>48</td>
<td>Non-covered Charges Total non-covered charges pertaining to the related revenue code in FL 42 are entered here. (required)</td>
<td>48 NON-COVERED CHARGES</td>
</tr>
<tr>
<td>49</td>
<td>Untitled (Not used)</td>
<td></td>
</tr>
<tr>
<td>50A-C</td>
<td>A (required) Enter the primary payer information</td>
<td>50 PAYER NAME</td>
</tr>
<tr>
<td></td>
<td>B (situational) Enter secondary payer information if applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C (situational) Enter tertiary payer information if applicable</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>A (required) Enter the primary payer plan identifier or the number assigned</td>
<td>51 HEALTH PLAN ID</td>
</tr>
<tr>
<td></td>
<td>B (situational) Enter secondary payer</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></td>
<td>plan identifier or the number assigned if applicable</td>
<td></td>
</tr>
<tr>
<td>C (situational) Enter tertiary payer plan identifier or the number assigned if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits Certification (not used)</td>
<td></td>
</tr>
<tr>
<td>54 A,B &amp; C</td>
<td>Prior Payments received amount to the provider towards this bill</td>
<td></td>
</tr>
<tr>
<td>55 A, B &amp; C</td>
<td>Estimated amount due from patient (not required)</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Billing provider National Provider ID (NPI) (required)</td>
<td></td>
</tr>
<tr>
<td>57</td>
<td>Other Provider ID (not used)</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>58 A, B &amp; C</td>
<td>Insured’s Name under whose name the insurance benefit is carried (required)</td>
<td>58 INSURED’S NAME</td>
</tr>
<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>
<td>59 P. Fiel d</td>
</tr>
<tr>
<td>60 A, B &amp; C</td>
<td>Insured’s unique ID number</td>
<td>60 INSURED’S UNIQUE ID</td>
</tr>
<tr>
<td></td>
<td>A – Required</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>B - Situational</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>C – Situational</td>
<td>C</td>
</tr>
<tr>
<td>61 A, B &amp; C</td>
<td>Insurance group name through which insurance is provided</td>
<td>61 GROUP NAME</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>62 A, B &amp; C</td>
<td>Insurance group number through which insurance is provided</td>
<td>62 INSURANCE GROUP NO.</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>63</td>
<td>Treatment authorization code or referral number assigned by the payer (situational)</td>
<td>63 TREATMENT AUTHORIZATION CODES</td>
</tr>
<tr>
<td></td>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td></td>
<td>B</td>
<td>B</td>
</tr>
<tr>
<td></td>
<td>C</td>
<td>C</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>64</td>
<td>Control number assigned to the original bill by the health plan for internal control (situational)</td>
<td>64 DOCUMENT CONTROL NUMBER</td>
</tr>
<tr>
<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>
<td>65 EMPLOYER NAME</td>
</tr>
<tr>
<td>66</td>
<td>Diagnosis and procedure codes (required).</td>
<td></td>
</tr>
<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>
<td></td>
</tr>
<tr>
<td>67A-67Q</td>
<td>Other Diagnosis Codes. Required when other condition(s) coexist or develop subsequently during the patient’s treatment</td>
<td></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>(situational)</td>
<td>68 Not used</td>
<td></td>
</tr>
<tr>
<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>
<td>69 ADMIT DX</td>
</tr>
<tr>
<td>70 A-C</td>
<td>Patient’s reason for visit (situational)</td>
<td>70 PATIENT REASON DX</td>
</tr>
<tr>
<td>71</td>
<td>Prospective Payment System (PPS) code (not used)</td>
<td>71 PPS CODE</td>
</tr>
<tr>
<td>72</td>
<td>External Cause of Injury (ECI) codes (not used)</td>
<td>72 ECI</td>
</tr>
<tr>
<td>73</td>
<td>Reserved (not used)</td>
<td></td>
</tr>
<tr>
<td>74</td>
<td>Principal procedure code and date (situational)</td>
<td>74 PRINCIPAL PROCEDURE CODE DATE</td>
</tr>
<tr>
<td>74A-E</td>
<td>Other procedure codes and dates (situational)</td>
<td>74 PRINCIPAL PROCEDURE CODE DATE</td>
</tr>
<tr>
<td>75</td>
<td>Reserved</td>
<td></td>
</tr>
<tr>
<td>76</td>
<td>Attending provider name and identifiers (including NPI)</td>
<td>78 ATTENDING NPI DATE</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>77</td>
<td>Operating provider name and identifiers (including NPI)</td>
<td>77 OPERATING NAME</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LAST</td>
</tr>
<tr>
<td>78</td>
<td>Other provider name and identifiers (including NPI)</td>
<td>78 OTHER</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LAST</td>
</tr>
<tr>
<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>
<td>80 REMARKS</td>
</tr>
<tr>
<td>81</td>
<td>Code-Code field (situational)</td>
<td>81 CODE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b</td>
</tr>
</tbody>
</table>

2. UB-04 Claim Form Sample
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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP on the CMS-1450 with the hospital’s request for payment.

Upon receipt, BlueCare Plus HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP 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 HMO D-SNP will authorize payment only if:

- The receiving facility initiated and followed the transfer review procedures of BlueCare Plus HMO D-SNP; 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.
Readmission Quality Program

31-Day Similar-Cause Readmission Quality Program

Consistent with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, BlueCross will reimburse for a thirty-one (31) day readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within three (3) and thirty-one (31) days after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay or admission resulting from a modifiable cause relating to the index admission discharge diagnosis, as determined by a Plan Medical Director.

- In this readmission scenario, the facility will be reimbursed only for a single inpatient DRG (the higher weighted of the two (2) admissions) and all other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for Medical Necessity.

- Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.

- If there is a second (2nd) readmission that occurs, still within thirty-one (31) days from the index admission discharge, then this will likewise bundle into the original admission, if the above parameters are met.

- Standard facility appeal remedies are still applicable. Note: The Member cannot be held liable for payment of services received when not authorized.

48 Hour Similar-Cause Readmission Quality Program

Consistent with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, BlueCross will reimburse for a forty-eight (48) hour readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within forty-eight (48) hours after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay or admission resulting from a modifiable cause relating to the index admission discharge diagnosis, as determined by a Plan Medical Director.

- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay. This penalty is due to the fact that CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.

- Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.
Standard facility appeal remedies are still applicable.

**Note:** The Member cannot be held liable for payment of services received when not authorized.

### 48 Hour Similar-Cause Readmission Quality Program

Consistent with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, BlueCross will reimburse for a forty-eight (48) hour readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within forty-eight (48) hours after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay or admission resulting from a modifiable cause relating to the index admission discharge diagnosis, as determined by a Plan Medical Director.

- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay. This penalty is due to the fact that CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.

- Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.

- Standard facility appeal remedies are still applicable.

**Note:** The Member cannot be held liable for payment of services received when not authorized.

**Effective Date:** July 1, 2017

### 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 HMO D-SNP 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), 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 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 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:

- 0250 – 0259 (Pharmacy)
- 0270 – 0279 (Surgical Supplies)
- 0290 – 0299 (DME)
- 0370 – 0379 (Anesthesia)

11. Skilled Nursing Facility (SNF)
In order for SNF services to be covered under BlueCare Plus HMO D-SNP, 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.bcbst.com/docs/providers/UM_Skilled_Nursing_Facility_Request_Fax.pdf](http://bluecareplus.bcbst.com/docs/providers/UM_Skilled_Nursing_Facility_Request_Fax.pdf) or fax to 1-866-325-6698.

BlueCare Plus HMO D-SNP has dedicated RN Care Coordinators available to assist you with necessary services for your BlueCare Plus HMO D-SNP 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 HMO D-SNP, 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 HMO D-SNP 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.

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.

Outpatient Rehabilitation
Freestanding Inpatient Rehabilitation facilities, Freestanding Outpatient Rehabilitation facilities, and Skilled Nursing facilities should bill BlueCare Plus HMO D-SNP 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 HMO D-SNP 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. N499999999999).
- 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 | Field Description | 837P Segment | 837I Segment  
--- | --- | --- | ---  
2400 | Drug Name description information | SV101-7 | SV202-7  
2400 | Drug Ingredient Billed Amount | SV102 | SV203  
2400 | HCPCS Unit of Measure | SV103 | SV204  
2400 | HCPCS Quantity | SV104 | SV205  
2410 | NDC Qualifier of N4 | LIN02 | LIN02  
2410 | NDC code (11 digits) | LIN03 | LIN03  
2410 | NDC Quantity | CTP04 | CTP04  
2410 | NDC Unit of Measure (F2, GR, ME, ML, UN) | CTP05-1 | CTP05-1  

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 HMO D-SNP 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>Last Name</td>
</tr>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>Patient Account</td>
</tr>
<tr>
<td>Member ID</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Number</td>
</tr>
<tr>
<td>Recv’d DT</td>
</tr>
<tr>
<td>Serv Prov</td>
</tr>
<tr>
<td>Date of Service From/Thru</td>
</tr>
<tr>
<td>Procedure/Modifier</td>
</tr>
<tr>
<td>Total Charges</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Non-Covered</td>
</tr>
<tr>
<td>Note</td>
</tr>
<tr>
<td>Contract Write Off</td>
</tr>
<tr>
<td>Note</td>
</tr>
<tr>
<td>Patient DED/COPAY</td>
</tr>
<tr>
<td>Field</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Patient COINS</td>
</tr>
<tr>
<td>Other Insurance</td>
</tr>
<tr>
<td>Claim Paid</td>
</tr>
<tr>
<td>Interest Paid</td>
</tr>
<tr>
<td>Patient Owes</td>
</tr>
</tbody>
</table>

Included is an example of the BlueCare Plus HMO D-SNP Remittance Advice

The patient deductible copay of coinsurance amounts should not be billed to the member. BlueCare Plus HMO D-SNP forwards these claims to the Bureau of TennCare for processing of member cost sharing.
BlueCare Plus HMO D-SNP 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.bcbs.com/providers/ecomms/, or you can contact us via email at eBusiness_Service@bcbs.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 HMO D-SNP, 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 HMO D-SNP 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 D-SNP - 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 HMO D-SNP.

A sample copy of the Risk Adjustment Medical Record Request letter follows:
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 HMO D-SNP 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,

Name
Medicare Advantage Risk Adjustment Department
BlueCross BlueShield of Tennessee

For additional information regarding risk adjustment, visit:
XIV. Quality Improvement Program

The BlueCare Plus HMO D-SNP 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 HMO D-SNP 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, as well as other structure and process measures. Each year, CMS provides guidance on HEDIS 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 HMO D-SNP 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.

The monthly updates to these contract and enrollment reports are scheduled to be published to the BlueCare Plus HMO D-SNP website by the 15th of each month.

Report that are currently available and a brief description of them is listed below.
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/MCRAdvPartDEnrolData/MEC/list.asp#TopOfPage).

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 in HPMS. 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. PFFS contracts are required to collect and report HEDIS summary-level data and patient-level data as outlined each year in the annual notice through HPMS.

B. Consumer Assessment of Health Providers and Systems (CAHPS)

CAHPS surveys are a set of surveys that collect 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 cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/CAHPS-Reports.html.

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)

CMS offers a listing of reports the annual CAHPS surveys on its website at www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ for additional reports.
C. STARS

CMS uses a five-star quality rating system to measure Medicare beneficiaries’ experience with their health plans and the health care 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, 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 HMO D-SNP 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 funding is used to protect, or in some cases, to increase benefits and keep member premiums low. BlueCare Plus HMO D-SNP 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 noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
Submit clinical data such as lab results to BCBST.
Communicate clearly and thoroughly; ask, “Do you have any questions?”
Understand each measure you impact.
Incorporate Health Outcomes Survey (HOS) questions into each visit. Find out more about HOS at http://www.hosonline.org/Content/SurveyInstruments.aspx.
Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to identify opportunities for you or your office to have an impact: http://mapdpcahps.org/content/surveyinstruments.aspx.

CMS has created the Health & Drug Plan Quality and Performance Ratings 2013 Part C & Part D Technical Notes, to review this document in its entirety follow the link provided, www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Technical-Notes-2013-.pdf.

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 2013 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. 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 HMO D-SNP currently uses for clinical quality improvement.

**XV. Provider Manual Change Document**

### Provider Manual Update

**Update 20170412**

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**Update 20170313**

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<td>Adding Education of Employees, Contract and Agents to Table of Contents</td>
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<td>20170313.27</td>
<td>03</td>
<td>Adding Non-Discrimination to Table of Contents</td>
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### Update 20170313

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<tr>
<td>20</td>
<td>Add section for <strong>Non-Discrimination</strong></td>
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<td>53</td>
<td>Changing sentence to read: <em>A physician may request to obtain</em> an expedited determination, by calling us at 1-866-789-6314</td>
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<tr>
<td>54</td>
<td>Adding <strong>Provider Dispute Procedure</strong></td>
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<td>160</td>
<td>Adding <strong>Re-Admission Reimbursement</strong> and Quality Program Information</td>
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<tr>
<td>02</td>
<td>Updating page numbers to <strong>Table of Contents</strong> to reflect additional information</td>
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### Update 20150624

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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>20150624.9</td>
<td>96</td>
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<tr>
<td>20150624.10</td>
<td>96</td>
<td>Corrected spelling from <strong>wither to whether</strong></td>
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<td>20150624.11</td>
<td>96</td>
<td>Added <strong>electronically or by fax</strong> to method of distributing ICT document</td>
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<td>20150624.12</td>
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<td>Remove ”or”, <strong>DUPLICATE</strong></td>
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### Update 20141110

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<td>166</td>
<td>Addition of <strong>National Drug Code Billing</strong> instructions including billing information regarding the filing a claim with an NDC number</td>
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<td>Page</td>
<td>Section</td>
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<tr>
<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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| 20141110.4 | 170  | 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. |
| 20141110.5 | 170  | 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. |
| 20141110.6 | 170  | 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. |
| 20141110.7 | 170  | • 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). |
| 20141110.8 | 171  | 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. |
| 20141110.9 | 171  | 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: |
| 20141110.10| 171  | 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). |
| 20141110.11| 171  | 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 HMO D-SNP partners with ValueOptions® of Tennessee to administer behavioral health care services for its BlueCare Plus HMO D-SNP 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 HMO D-SNP 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

Replacing "ValueOptions" with BlueCare Plus

Removing "valueoptions.com"

Removing the word "and"