Blue Advantage (HMO) Provider Administrative Manual

Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Enrollment in HMO Louisiana, Inc. depends on contract renewal. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, independent licensees of the Blue Cross and Blue Shield Association.
Welcome to Blue Advantage (HMO)

Thank you for participating in the Blue Advantage (HMO). As a participating provider, you play an important role in the delivery of healthcare services to Blue Advantage Plan members, and you have our commitment to work collaboratively with you to provide members access to excellent care and coverage.

This Blue Advantage Provider Administrative Manual is intended to be used as a guide to assist providers in delivering covered services to Blue Advantage members. This manual contains policies, procedures and general reference information, including minimum standards of care, which are required of Blue Advantage providers and govern the administration of the Medicare Advantage and Prescription Drug (MA-PD) plan, which is called Blue Advantage. This manual also contains a brief summary of the Blue Advantage plan, an overview of the Medicare Advantage Program and the Blue Advantage MA-PD benefit plan, Blue Advantage. When this manual says “we,” “us” or “our,” it means Blue Advantage. When it says “plan” or “our plan,” it means Blue Advantage plan.

This information is provided to promote an effective understanding of Blue Advantage operations and supplements the provider participation contract. This manual is available on the Blue Advantage Provider Portal, which is accessible through iLinkBlue (www.bcbsla.com/ilinkblue) by clicking on the “Blue Advantage” menu option. A paper copy of the manual can be obtained at no charge by contacting Blue Advantage Customer Service. The contact information is in the Plan Information Contact List located in the front of this manual.

Blue Advantage may revise this manual to reflect changes in policies and procedures, and all such revisions shall be in effect (30) calendar days after notice or such lesser time for plan compliance with laws, Centers for Medicare & Medicaid Services (CMS) requirements or accreditation requirements. Providers are notified of changes to the Provider Administrative Manual by mail, email, notices of update posted on our website or other electronic means.
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## Plan Information Contact List

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| **Blue Advantage Provider Portal**     | For assistance with routine inquiries such as claim status checks, member eligibility, benefit verification or confirmation of prior authorization, use the Blue Advantage Provider Portal, located within iLinkBlue (www.bcbsla.com/ilinkblue), then click on “Blue Advantage” on the menu bar.  
For technical questions relating to registration or login access to the Blue Advantage Provider Portal:  
phone: 1-866-508-7145                                                                                                                                                                                                                                                                       |
| **Blue Advantage Customer Service**    | For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Service at:  
phone: 1-866-508-7145  
fax: 1-877-528-5820  
email: customerservice@blueadvantage.bcbsla.com  
mail: HMO Louisiana, Inc.  
P.O. Box 32406  
St. Louis, MO 63132  
online: www.bcbsla.com/blueadvantage                                                                                                                                                                                                                                           |
| **Authorizations (including Case and Medical Management)** | Radiation Oncology Program authorizations:  
To request a prior authorization for radiation therapy services, use AIM Specialty Health’s Provider Portal, available on iLinkBlue under the Authorizations and Medical Policy menu option. For assistance related to a prior authorization for an advanced radiological imaging or radiation therapy service, contact AIM Specialty Health at:  
online: via AIM’s ProviderPortalSM available 24 hours a day, seven days a week through iLinkBlue (www.bcbsla.com/ilinkblue). It is fully interactive, processing requests in real-time.  
phone: 1-866-455-8416  
All other services that require an authorization:  
To request prior authorization for these services download the Prior Authorization Form from the Blue Advantage Provider Portal (available on iLinkBlue at www.bcbsla.com/ilinkblue) or for assistance with case management, notification and benefit determinations, contact the Blue Advantage Medical Management team at:  
phone: 1-866-508-7145, option 4, option 4  
fax: 1-877-528-5816  
1-877-528-5818 (for inpatient)                                                                                                                                                                                                 |
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| Behavioral Health     | Blue Advantage members use New Directions Behavioral Health for their behavioral health needs.  
Facility authorizations (inpatient and outpatient) should be submitted through the **Authorizations Portal**, available on iLinkBlue ([www.bcbsla.com/ilinkblue](http://www.bcbsla.com/ilinkblue)) under the “Authorizations and Medical Policy” menu option > Behavioral Health.  
phone: 1-877-250-9167  *(for customer service and non-facility authorizations)*  
mail: HMO Louisiana, Inc.
P.O. Box 32406
St. Louis, MO 63132 |
| Outpatient Laboratory Tests | Send Blue Advantage members to a Blue Advantage network reference laboratory:  
Clinical Pathology Labs (CPL)  
phone: 1-800-595-1275  
online: [www.cpllabs.com](http://www.cpllabs.com) |
| Pharmacy *(for Part D Prescriptions)* | Blue Advantage members with Part D use the Express Scripts, Inc. pharmacy network:  
phone: 1-800-935-6103/TTY:1-800-716-3231  
fax: 1-877-328-9799  
mail: ESI – Attn. Medicare Reviews  
P.O. Box 66571  
St. Louis, MO 63166-6571  
online: [www.covermymeds.com](http://www.covermymeds.com)  
[www.express-path.com](http://www.express-path.com) |
| Dental                | Blue Advantage members with preventive dental coverage use United Concordia Dental (UCD). Providers must be contracted directly with UCD to be in-network for members:  
phone: 1-866-445-5825  
mail: *(claims address)*  
United Concordia Dental  
P.O. Box 69441  
Harrisburg, PA 17106-9420 |
| Vision                | Blue Advantage members with routine eye care and vision services coverage use Davis Vision:  
phone: 1-800-247-2814  
mail: *(claims address)*  
Vision Care Processing Unit  
P.O. Box 1525  
Latham, NY 12110 |
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| **Fitness Program**          | Blue Advantage members may have fitness benefits (contingent on their plan type) through American Specialty Health (ASH). Members with this benefit can arrange for membership on their own for the following program:  
   Sliver & Fit  
   phone: 1-877-427-4788 |
| **Transportation Services**  | Blue Advantage members may have limited non-emergent transportation services available to them (contingent on their plan type). For assistance with transportation services, contact Medical Transportation Management:  
   phone: 1-844-250-6993  
   Blue Advantage members can self-schedule non-emergent transportation services.  
   Blue Advantage members are limited to six one-way trips to approved locations at no cost. Members may make their own arrangements by calling 1-888-513-0705, available 24 hours a day, seven days a week.  
   Parishes where transportation benefit is available:  
   • (Baton Rouge Area) Ascension, East Baton Rouge, Livingston, St. Helena and West Baton Rouge parishes  
   • (Greater New Orleans Area) Jefferson, Orleans, St. Charles, St. James and St. John the Baptist parishes |
| **Disputes**                 | For assistance related to contract disputes:  
   phone: 1-866-508-7145  
   fax: 1-877-528-5820  
   mail: HMO Louisiana, Inc. Provider Disputes  
   P.O. Box 32406  
   St. Louis, MO 63132 |
| **Compliance/Fraud Waste and Abuse** | For questions related to Blue Advantage's program and code of conduct and the provider’s responsibility relative to the Compliance Program, including required training; reporting any suspected or actual violation of regulations, laws, policies or procedures or fraud, waste and abuse:  
   Compliance and Ethics Hotline  
   phone: 1-800-973-7707  
   Fraud, Waste and Abuse Hotline  
   phone: 1-800-392-9249  
   fax: (225)295-2599  
   email: compliance.office@bcbsla.com  
   mail: Blue Advantage Compliance  
   P.O. Box 84656  
   Baton Rouge, LA 70884-4656 |
### ACT Specialist
The ACT Specialist is a specialized representative whose role is to assist primary care providers (PCPs) with achieving contract performance measure goals through implementation of tools, such as the Accountable Delivery System Platform (ADSP). ACT Specialists actively outreach to Blue Advantage network PCPs. The ACT team may also be contacted:

email: accountablecareteam@blueadvantage.bcbsla.com

For registration, login, or application access questions regarding the Blue Advantage Provider Portal and ADSP, please contact ADSP Customer Support:

phone: 1-866-397-2812
email: customersupport@lumeris.com
fax: (314)898-4216

### Network Development
For questions on how to join the Blue Advantage provider network:

phone: 1-800-716-2299, option 1
email: network.development@bcbsla.com

### Network Operations
For changes to your address or other provider file related maintenance:

phone: 1-800-716-2299, option 3
email: network.administration@bcbsla.com

Changes about your practice can be communicated through the Blue Advantage Provider Portal, located within iLinkBlue (www.bcbsla.com/ilinkblue), then click on “Blue Advantage” on the menu bar.

or

Changes may be submitted on the Provider Update Request Form (located in the back of the Blue Advantage Provider Manual):

fax: 225-297-2750
mail: Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

### Provider Relations
For assistance with detailed and complex issues that have not been resolved through the Provider Portal or by Customer Service:

phone: 1-800-716-2299, option 4
email: provider.relations@bcbsla.com
Background
The business of healthcare is changing rapidly and Blue Cross and Blue Shield of Louisiana, along with its subsidiaries, is changing with it. Our goal is to continue being the industry leader in our state.

Our Mission
To improve the health and lives of Louisianians.

Under our new mission, we are assuming a more direct role in Louisiana’s health. We will do this by dramatically improving:

- Quality of Care
- Our Member Experience

Our Vision
To be the market leader that delivers unsurpassed value to our customers through partnerships across the healthcare system.

Our Brand Promise
We help Louisianians protect every day: from getting sick, from worrying about how to pay for it and from taking life off track because of it.

Our Model
The first Collaborative Payer® Model is built on a foundation of reciprocal accountability, aligned patient and provider incentives, cultural and data transparency, and information and technology tools that support continuous improvement and behavior change. It favors the wellness of patients and fosters stewardship of healthcare resources in pursuit of the Triple Aim Plus One: better health outcomes, lower costs and improved patient experience plus physician satisfaction. We:

- Partner with progressive medical groups and physician organizations to establish, design and locally manage a Medicare Advantage health plan in their own community.
- Provide the most generous healthcare benefits to members at the lowest out-of-pocket costs in every community we serve.
- Properly align financial incentives, affording our physician partners the time and funds necessary to spend more time with patients, allowing them to focus on the long-lasting health of their patients.
- Empower physicians to make the most appropriate care decisions for their patients.
- Proactively share clinical and financial data, revenue and risk with our physician partners.
- Help our physician partners to economically and successfully leverage technology to control costs, improve income and provide outstanding patient care.
**Provider Assistance**

If you are a primary care provider (PCP), you have direct support for all issues related to the plan through your Blue Advantage ACT Specialists and Blue Advantage Customer Service Representatives. Their focus is to assist you with our Accountable Delivery System Platform (ADSP)*, and deal with any issues you may have with the plan.

If you are not a PCP but are a contracted provider, you too have assistance through our Customer Service Department. Should you need assistance beyond this department, please contact provider.relations@bcbsla.com.

*explained on page 17

**Our Product**

Our plan offers Medicare recipients an excellent alternative to the options they currently have available, with a comprehensive benefit package that covers more than traditional Medicare. Members have coverage available for a wide array of services including outpatient prescription drug coverage, hospitalization and home care, preventive care services and ambulance transport, as long as the service is medically necessary and rendered by a participating provider. Blue Advantage members may have a copayment or coinsurance they are responsible to pay for some covered services.

Blue Advantage members select a PCP at the time of enrollment. The member’s PCP will be responsible for providing, coordinating and arranging all medically necessary services for the member.

Blue Advantage is available in Louisiana to members residing in the parishes of Ascension, East Baton Rouge, Jefferson, Livingston, Lafayette, Orleans, St. Charles, St. James, St. John the Baptist, St. Helena, St. Landry, St. Tammany, Washington and West Baton Rouge.

**Selecting a Primary Care Provider (PCP)**

Upon enrollment with Blue Advantage, a member must choose a physician to be their Primary Care Provider (PCP). In rare cases, if the member has not identified a PCP and we cannot verify his/her choice, a PCP may be assigned. The member may select a different PCP by contacting Blue Advantage Customer Service. The contact information is in the Plan Information Contact List located in the front of this manual.

A PCP serves as the member’s total care coordinator for non-emergent care.

PCPs are available to members 24 hours a day, seven days a week through regular scheduling or on-call coverage. There will always be a doctor on call to help them.
Changing a Primary Care Provider (PCP)

It is important that members have a good relationship with their PCP, as they provide most of their care. Members can change their PCPs to another Blue Advantage contracted PCP at any time for any reason. Members can do so by contacting Blue Advantage Customer Service. The contact information is in the Plan Information Contact List located in the front of this manual. The change will be effective the first day of the month following receipt of the member’s request.

In rare situations, a member may be retroactively assigned to a PCP. For example, the member’s PCP may have terminated the contract without notification because of illness or death. We will assist the member in finding a new PCP as quickly as possible to promote continuity of healthcare and coverage, but there may be a slight time lapse that causes the assignment to have a retroactive effective date.

We suggest you put office procedures in place to confirm via our online member eligibility look up that you are the PCP of record prior to a member’s appointment.

Compliance Responsibilities for Blue Advantage Providers

As a Medicare Advantage Organization (MAO) with an established contract with the Centers for Medicare & Medicaid Services (CMS), Blue Advantage is required to communicate its compliance program requirements to providers and ensure compliance with these requirements. Providers contracted with Blue Advantage to provide medical or administrative services to our members are required to comply with all applicable Medicare laws, regulations, reporting requirement and CMS instructions, with all other applicable federal, state and local laws, rules and regulations; to cooperate with Blue Advantage in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and to ensure that all healthcare professionals employed by or under contract to render health services to Blue Advantage members, including covering physicians, comply with these provisions.

Blue Advantage requires written attestation of such compliance through its provider contracting process as well as through its contracted entity compliance training and education program. We may send written notification to providers and other contracted entities with a description of the compliance training and education requirements and a request to attest that our Code of Conduct, selected policies and procedures and other compliance-related documents (or their equivalents) are read, followed and distributed to any individuals employed or contracted by the entity to provide medical or administrative services to Blue Advantage Plan members.

Upon request, your attestation of compliance must be completed within 60 days of notification.

Responsibility to Check for Exclusions

Medicare payment may not be made for items or services furnished or prescribed by a provider or entity that has been excluded by the Department of Health and Human Services Office of Inspector General (OIG) or General Services Administration (GSA). Providers have compliance responsibility for routinely verifying that no employees or contracted entities that perform administrative or healthcare service functions relating to Blue Advantage are excluded by the OIG/GSA, and should immediately communicate any such exclusion to Blue Advantage Louisiana’s Compliance Department.
Reporting Compliance Concerns

Actual or suspected Medicare program noncompliance, potential fraud, waste and abuse, or any compliance concerns or violations relating to the Blue Advantage plan or its members must be reported. Providers must ensure that employees or contracted entities that perform administrative or healthcare service functions relating to Blue Advantage are aware of our expectations of reporting and its policy of non-intimidation and non-retaliation for good-faith reporting of compliance concerns and participation in the compliance program. Information about how to report compliance concerns is denoted in the front of this manual and should be publicized or otherwise made available throughout your facilities.

Guidelines for Providers When Discussing Medicare Advantage

Healthcare providers and their staff must remain neutral parties when discussing Medicare coverage options with their patients.

Healthcare providers and their staff must not:

- Offer Medicare Advantage and/or Part D sales/appointment forms to Medicare beneficiaries.
- Accept enrollment applications for Medicare Advantage plans and/or Medicare Part D plans.
- Make phone calls in regards to or direct, urge or attempt to persuade Medicare beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mail marketing materials to Medicare beneficiaries on behalf of Medicare plan sponsors.
- Offer anything of value to induce Medicare plan enrollees to select them as their healthcare provider.
- Offer inducements to persuade Medicare beneficiaries to enroll in a particular Medicare Advantage/Part D plan or organization.
- Perform health screenings in direct or indirect connection with the sharing of information about Medicare coverage options.
- Accept compensation directly or indirectly from a Medicare Advantage and/or Medicare Part D plan for beneficiary enrollment activities.
- Conduct or facilitate sales activities in patient service areas (i.e. exam rooms, waiting rooms).

Healthcare providers and their staff are permitted to:

- Provide the names of all Medicare Advantage and/or Part D plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Medicare Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials for a subset of contracted Medicare plans, so long as the provider offers the option of making available and/or distributing marketing materials to all plans with which they participate.
- Provide objective information on Medicare plan sponsors’ specific plan formularies, based on a particular patient’s medications and healthcare needs should a beneficiary seek advice.
- Provide objective information regarding plan sponsors’ plans, including information such as covered benefits, cost sharing and utilization management tools should a beneficiary seek advice.
- Refer their patients to other sources of information, such as SHIPs, their state Medicaid office, local Social Security office, Medicare website (www.medicare.gov) or the Medicare helpline, 1-800-MEDICARE (1-800-633-4227).
- Print out and share information with patients from the Medicare website.
- If patients ask, you can provide the name of the plan marketing representative.

**Non-discrimination Agreement**

PHYSICIAN agrees: (1) not to deny, limit, condition, differentiate or discriminate in its provision of services to MA Members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, health status (which includes, but is not limited to, medical condition, including mental as well as physical illness, claims experience, receipt of health care, payor identity, medical history, genetic information, and evidence of insurability, including conditions arising out of acts of domestic violence), disability, source of payment, enrollees' complaint or grievance in connection with any evidence or certificate of coverage, age, or whether or not an MA Member has executed an advanced directive; and (2) to render services to enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to non-plan patients consistent with existing medical ethical/legal requirements for providing continuity of care to any patient. Without limiting the generality of the foregoing, PHYSICIAN expressly agrees to comply with Title VI of the Civil Rights Act of 1964 and 45 C.F.R. 84; the Age Discrimination Act of 1975 and 45 C.F.R. 91; the Americans with Disabilities Act, and its amendments; the Rehabilitation Act of 1973; other laws applicable to recipients of federal funds; and all other applicable federal and state laws, rules and regulations. Without limiting the generality of the foregoing, PHYSICIAN shall make its services available to MA Members on the same basis and time limits as those made available to patients who are not members of a plan (42 C.F.R. § 422.110).
Blue Advantage Member ID Card

Blue Advantage provides each member with an identification card. This card contains demographic information about the covered member, as well as important coverage information such as PCP name and phone number, copayment or coinsurance responsibilities and important phone numbers.

Blue Advantage encourages providers to make a copy of the member’s card for their records. We also encourage you to confirm with members each time you see them, if their insurance coverage has changed and if you are their PCP. The date on the card represents their effective date with the plan, not necessarily the effective date with the PCP.

You may confirm member eligibility, current assigned PCP, maximum out-of-pocket and Coordination of Benefits (COB) information via our online Blue Advantage Provider Portal. It is the member’s responsibility to present his or her member ID card at the time medical services are obtained.

Below is an example of a Blue Advantage member ID card. ID cards are issued in the subscriber’s name only. Each Blue Advantage member ID card is used for all types of coverage:

Blue Advantage Specialists

To help your Blue Advantage patients find specialists in their network, direct them to the Blue Advantage Member Portal, available at www.bcbsla.com/blueadvantage >Find a Doctor.

Blue Advantage Member Rights and Responsibilities

Each Blue Advantage member has the right to:

- Be treated with dignity, respect and fairness at all times.
- Receive advice or assistance in a prompt, courteous and responsible manner.
- Confidentiality. All information concerning enrollment and medical history is privileged and confidential except when disclosure is required by law or permitted in writing. Blue Advantage members are entitled to access their medical records according to state and federal law free of charge; and with adequate notice, they have the right to review their medical records with their physician. Blue Advantage members also have the right to ask plan providers to make additions or corrections to their medical records.
Choose a Blue Advantage contracted primary care physician. Members are asked to establish an ongoing relationship with their physician. Blue Advantage members have the right to change physicians at any time and for any reason.

Get appointments and services within a reasonable amount of time (See Appointment Scheduling and Waiting Time Guidelines).

Participate fully in decisions about their healthcare and have providers explain things in a way they can understand. This includes knowing all treatment choices recommended for the condition, no matter what they cost or whether they are covered by Blue Advantage.

Ask someone such as a family member or friend to help with decisions about healthcare. To have a guardian or legally authorized person exercise their rights on their behalf if their medical condition makes them incapable of understanding or exercising their rights.

Make a complaint if they have concerns or problems related to coverage or care.

Information about Blue Advantage, its services, its participating physicians and other healthcare providers providing care and members’ rights and responsibilities.

Discuss healthcare concerns or complaints about Blue Advantage with those responsible for their care or with Blue Advantage and to receive a response within a reasonable time period.

**Cultural Competency**

Cultural competency is a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural similarities and differences, and to understand how these differences influence relationships and interactions with members. Members are entitled to dignified, appropriate and quality care, with sensitivity to cultural differences.

Network providers must ensure the following:

- Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them.

- Care is provided with consideration of the member’s race/ethnicity and language and its influence on the member’s health or illness.

- Office staff that routinely comes in contact with members has access to and participate in cultural competency training and development.

- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific information. Staff will also explain race/ethnicity categories to a member so the member is able to identify the race/ethnicity of themselves and their children.

- Treatment plans are developed and clinical guidelines are followed with consideration of the member’s race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.

- Office sites have printed and posted materials in English, and all other prevalent non-English languages if required.
Second Opinions

Blue Advantage members have the right to receive a second opinion should they desire to do so. If the second opinion fails to confirm the primary recommendation for a treatment plan or if the member so desires, a third opinion, provided by a third provider can be sought. If there is no qualified physician to perform the second or third opinion consultation within the Blue Advantage provider network, the PCP will need to contact the Medical Management department for assistance and approval to go outside the network for the consultation.

Advance Directives

Members have the right of self-determination. An Advance Directive enables an individual to outline, in advance of a serious illness, what kind of treatment the person wants or does not want, should they become unable to decide or speak for themselves.

Because this is an important matter, members are advised to talk to family, close friends and their physicians before completing an Advance Directive.

The two most common forms of Advance Directives are a Health Care Directive (Living Will) and Durable Power of Attorney for Health Care.

A Health Care Directive is a document that allows individuals to state in advance their wishes regarding the use of life-prolonging procedures. It may be relied upon if individuals become unable to communicate their decisions. It is sometimes called a “Living Will.” In most states, adults may complete and sign a pre-printed form or draw up their own forms.

A Durable Power of Attorney for Health Care is a signed, dated and notarized legal document that allows individuals to appoint someone to make healthcare decisions for them if they are not able to do so. These decisions may include instructions about any treatment they desire or those they wish to avoid, including decisions to withhold or withdraw life-prolonging procedures.

Blue Advantage participating physicians are encouraged to ask their patients if they have an Advance Directive and are advised to place a signed, notarized copy of any Advance Directives in patients’ medical records.

Individuals may change their minds or cancel either document at any time in accordance with state laws. Any change or cancellation should be written, signed and dated in accordance with the applicable state law and copies given to their healthcare providers.

If an individual wishes to cancel an Advance Directive while in the hospital, the individual should notify the treating physician, PCP, family members and others who may need to know.

For those who live in Louisiana, you can find further information, including advance directive forms, on the Office of the Attorney General State of Louisiana website at www.ag.state.la.us/.
**Member Orientation**

Blue Advantage customer service representatives are available to assist members once they have enrolled in the plan. These representatives can provide a variety of information to the member. Members may contact Blue Advantage Customer Service with questions, such as:

- the role of the PCP
- how to access a specialist
- criteria for emergency room coverage
- use of their member ID card
- medical and prescription drug benefits

If you believe your patient is confused about their benefits or has general questions about the plan, you may call Blue Advantage Customer Service on the patient’s behalf and request that a representative call the member to assist the individual. The contact information is in the Plan Information Contact List located in the front of this manual.

**Explanation of Benefits**

Blue Advantage issues two types of explanation of benefits (EOB) to members:

1. A medical EOB is generated monthly and reflects all claims processed the prior month with the exception of services, which are rejected back to the provider of service. Rejected claims are claims which require additional or corrected information in order to consider the service for benefits. (An example of rejects are claims that require a corrected procedure code or a primary carrier’s EOB).

2. A Part D prescription drug EOB is generated monthly and reflects both the prior month’s Part D claims activity as well as the member’s year-to-date total drug spend and true out-of-pocket costs, which determines the phase of the Part D benefit the member is currently in.

Members can also obtain real-time information online via our website once they establish a secure login and password. EOBs are only issued if the member has had claims activity the prior month.

**Making Changes in Healthcare Coverage**

Medicare restricts the number of times beneficiaries can voluntarily change their membership in a health plan. When a beneficiary is new to Medicare, the individual is given an Initial Coverage Election Period (ICEP) that allows the beneficiary to enroll in a Medicare Advantage plan. After the ICEP there is one primary time, the Annual Enrollment Period (AEP), when all Medicare beneficiaries may choose to make a change to the way they receive Medicare Coverage. The AEP is the time when all beneficiaries should review healthcare and drug coverage options for the upcoming year and are able to make changes that will be effective January 1 of the following year.

The Medicare Advantage Disenrollment Period (MADP) is the time when all beneficiaries can disenroll from the plan and return to Traditional Medicare.

Individuals may also qualify for what is called a Special Election Period (SEP). An SEP is a special timeframe outside the normal AEP when an individual may make a change to membership in a health plan, such as enroll in a new plan or request to disenroll from an existing plan. Examples of circumstances that warrant an SEP include but are not limited to the following: individuals who qualify for Medicaid benefits, individuals who get extra help (low income subsidy) and individuals who move out of the service area.
For more information on when changes can be made, see the enrollment table below (please note that this is not an all-inclusive list of available SEPs).

<table>
<thead>
<tr>
<th>Enrollment period</th>
<th>When?</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Coverage Election Period (ICEP)</strong></td>
<td>Starts three months before the beneficiary's first entitlement to both Medicare Parts A and B</td>
<td>Determined by the entitlement dates and the date the enrollment request is received</td>
</tr>
<tr>
<td>The beneficiary is given one ICEP when they are first eligible for both Medicare Part A and B. During this period a beneficiary may enroll in a Medicare Advantage Plan.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fall Open Enrollment</strong> (Annual Election Period)</td>
<td>From October 15 to December 7</td>
<td>January 1</td>
</tr>
<tr>
<td>Time to review health and drug coverage and make changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Advantage Disenrollment Period (MADP)</strong></td>
<td>From January 1 to February 14</td>
<td>First day of next month after plan receives the disenrollment request</td>
</tr>
<tr>
<td>A beneficiary who is enrolled in a MA or MAPD plan may disenroll:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• These individuals may enroll in a stand-alone PDP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• These individuals may not use the MADP to enroll into an MA or MAPD plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Special Enrollment Periods (SEP)</strong> for limited special circumstances such as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary has a change in residence</td>
<td>Determined by the SEP</td>
<td>Determined by the SEP</td>
</tr>
<tr>
<td>• The beneficiary has Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary becomes eligible when they have, are getting or are losing their low income subsidy (LIS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary goes to live in an institution (such as a nursing home)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary qualifies for a Qualified State Pharmaceutical Assistance Program (SPAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary was a member of a special needs plan, but lost the special needs qualification required to be in that plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• The beneficiary has employer group coverage or is losing employer group coverage</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Blue Advantage Provider Portal

Available through iLinkBlue (www.bcbsla.com/ilinkblue)

The Blue Advantage Provider Portal allows Blue Advantage network providers access to information that assist in improving patient care and office efficiency. Providers in our Blue Advantage network must access and manage eligibility, benefits, claims and more electronically, through iLinkBlue. By accessing the Blue Advantage Provider Portal, providers will have access to:

- Blue Advantage Provider Administrative Manual
- Blue Advantage Provider Quick Reference Guide
- Blue Advantage Provider Directory
- Blue Advantage Drug Formulary Search
- Member Eligibility Inquiry for Providers
- Claim Inquiry for Providers
- Authorization Inquiry
- Blue Advantage Provider Forms

Administrative Representative

In early 2017, iLinkBlue will be moved under a higher level of security to meet additional compliance requirements. To access the new iLinkBlue, providers must have a security administrative representative. To learn how to register your administrative representative and report him/her to Blue Cross, visit www.bcbsla.com/providers.

Accessing the Blue Advantage Provider Portal

To access the Blue Advantage Provider Portal, all network providers will need an iLinkBlue username and password. If the provider does not have a valid iLinkBlue account, they must register to obtain an iLinkBlue username and password.

To obtain access to the Blue Advantage Provider Portal:

1. Log on to www.bcbsla.com/ilinkblue.
2. Click the “Enter iLinkBlue” button and the Windows Security screen will be displayed.
3. Type in your username and unique password in the password field.
4. Click “OK.” If your username and password was entered correctly, your logon should be successful. Please remember to not place a check mark in the “Remember my Password” field.
5. The iLinkBlue main menu will be displayed.
6. From the iLinkBlue main menu, select Blue Advantage (located under the “Estimated Treatment Cost” button on the iLinkBlue main menu).
PCP Provider Information

Provider Reports for PCPs
Between the 2nd and the 15th of each month, the administrative group level within the ADSP Portal for each PCP office, will receive electronic files with reports including eligibility information, medical and pharmacy claims data, capitation and premium information, Blue Advantage news and updates. The administrative group level is then responsible to forward this information to each individual PCP office.

Daily Inpatient Hospital Census and Prospective Inpatient Admissions are available to all PCPs via their group’s administrator.

Accountable Delivery System Platform (ADSP)
The ADSP is a Web-based informatics application containing a set of tools designed to put information in the hands of contracted primary care providers. The information is provided in a series of reports and criteria-driven rules that allow a unique vantage point into the patient’s health status across the entire continuum of care. The platform aggregates and analyzes data—including medical claims, EMR encounter data and lab and pharmacy data—to provide a comprehensive view of patient care. It then sends actionable clinical and financial data to physicians and other stakeholders at the point of medical decision-making to enable timely value-based healthcare decisions. This information is also intended to help monitor the patient population’s chronic diseases and co-morbidities to improve patient outcomes and successfully practice medicine within a risk-adjusted Medicare reimbursement model.

How to Access the ADSP
Access to ADSP is located within the Blue Advantage Provider Portal and available to primary care providers only.

Go to www.bcbsla.com/ilinkblue:

1. Select Blue Advantage on the main menu of iLinkBlue
2. Select the Blue Advantage Provider Portal option
3. Once logged into the Blue Advantage Provider Portal, there will be a link to the ADSP
**Appointment Scheduling and Waiting Time Guidelines**

All Blue Advantage network providers must use their best effort to adhere to the following standards for appointment scheduling and waiting time:

<table>
<thead>
<tr>
<th>Service</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP-New Patient</td>
<td>Within 30 days of the patient’s effective date on the PCP’s panel – to be initiated by the PCP’s office</td>
</tr>
<tr>
<td>Routine Care without symptoms</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Non-routine Care with symptoms</td>
<td>Within five business days or one week</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>Emergency</td>
<td>Must be available immediately 24 hours per day, seven days per week via direct access or coverage arrangements</td>
</tr>
</tbody>
</table>
| OB/GYN                         | 1st and 2nd trimester within one week  
3rd trimester within three days  
OB emergency care must be available 24 hours per day, seven days per week |
| Phone calls to the provider office from the member | Same day; no later than next business day |

- Routine care without symptoms includes physical exams and well-woman exams.
- Non-routine care with symptoms includes rashes, coughs and other non-life-threatening conditions.
- Urgent Care is defined as medical conditions that could result in serious injury or disability if medical attention is not received.
- Emergency is defined as medical situations in which a member would reasonably believe his/her life to be in danger or that permanent disability might result in the condition is not treated.

Practitioners should make every effort to see the patient within an average of one hour from the patient’s scheduled appointment time. This includes time spent both in the lobby and the examination room.

Members who are late for their scheduled appointments may not be able to be seen within the hour.

**PCP Patient Access**

Blue Advantage encourages all new members to get established with their PCPs and not wait until they are sick or experience health problems. We understand that medical issues can arise prior to the member becoming established with the practice and those problems need to be addressed by the PCP’s office until the initial appointment can be completed. It may be warranted to prepare front office personnel to ask appropriate questions of the member when they call in order to triage and resolve the medical need(s) of the member.
Verifying Member Eligibility for All Providers

We encourage all participating providers to utilize the Blue Advantage Provider Portal for standard member eligibility and plan benefit confirmation. This allows the Customer Service staff to be available to address more complex issues that cannot be handled via an automated process.

Current member eligibility can be found online with appropriate security access by all providers.

At the beginning of each month, eligibility reports will be sent to all administrative PCP groups. Throughout the month, you may also check member eligibility online by going to www.bcbsla.com/ilinkblue, then click the Blue Advantage menu option. A secure logon will be needed to access this information.

Per CMS guidelines you will need four pieces of information to access/confirm member eligibility, including:

- Member’s first name or initial
- Member’s last name
- Member’s Blue Advantage ID or Medicare Health Insurance Claim Number (HICN), (typically 9 digits and an alpha)
- Member’s date of birth

In addition to eligibility, we provide additional information on this screen that includes:

1. Up-to-date information regarding the member’s maximum out-of-pocket (MOOP)
2. The member’s current PCP
3. Coordination of Benefits (COB) information

Members have access to their “eligibility” through the Blue Advantage Member Portal.

Covering Physician Policy

PCPs with a capitation arrangement with us need to make appropriate arrangements to pay a covering physician for services that are rendered on your behalf so the covering physician will get paid fee for service.

Online Claim Inquiry for All Providers

Blue Advantage encourages all network providers to utilize the Blue Advantage Provider Portal for standard claims status checks. This allows the Customer Service staff to be available to address more complex issues that cannot be handled via an automated process.

Once a claim has been submitted it can be found online by going to the Blue Advantage Provider Portal, available at www.bcbsla.com/ilinkblue, then click the Blue Advantage menu option. A secure logon is needed to access this information.

There are two ways you can inquire about a claim: 1) by date range or 2) by a specific claim ID.

For each listed claim, the screen displays the claim number, dates of service, provider, member name, claim status, date of the claim status and payment amount. A detailed summary is provided for all finalized claims. Please note that if the status of the claim is “In Process” you will not be able to review the detail. The summary detail screen provides a brief summary, a payment detail and a summary of each line item.
Operations

Terminating a Relationship with a Patient

It is the physician’s responsibility to take reasonable efforts to develop and maintain a positive patient-physician relationship. In the event that such a relationship cannot be established the steps outlined below are to be followed:

- **Call the Blue Advantage Customer Service department** and notify us that you are unable to establish or maintain a positive physician-patient relationship. Provide your name and title, member’s name and ID number and a contact number where you can be reached. Please do not send correspondence to the member terminating a relationship prior to notifying us.

- The Customer Service department will transfer your contact information to the Quality Improvement department who will contact you within one business day to collect the documentation needed to process the termination. The Quality Improvement department will inform you of the types of documentation you may submit supporting your position, including phone logs and medical record documentation. Documentation must demonstrate a diligent effort including a minimum of three attempts by the PCP to establish and/or maintain a relationship.

Blue Advantage may choose to attempt contact with the patient/member prior to additional action by the physician office. You will be informed if this step will be taken.

- If Blue Advantage chooses not to make contact with the patient/member, you will be directed to send a certified letter (with return receipt) to the patient giving, in detail, the reason for terminating the relationship. The letter will include a date by which the patient is expected to make a PCP change. The physician must allow the patient a MINIMUM of 30 days in which to select a new PCP. The patient will be effective with the new PCP the first day of the next month following the change. Until that time, you will be responsible for all aspects of the patient’s healthcare needs.

- If the member does not choose a new PCP, we will assign the member to another PCP within reasonable proximity to the member’s residence or your practice. We will make every effort to successfully transfer the member to a new PCP by the date specified in the letter. Please note that the member will have the ability to select another PCP within the PCP’s independent practice association, if applicable, but not within your specific practice.

- You must assist in the member’s transfer of care by providing a copy of the complete medical file and, if relevant, discussing care issues with the newly selected PCP.

**Note:** A request to terminate the relationship with a patient must be based on an inability to establish or maintain an effective physician-patient relationship. A member may not be terminated from the provider’s care based upon any of the following: a) health status; b) the cost of providing services to the patient; c) the termination of a family member; d) the member being institutionalized or home-bound; e) the member’s ability to pay; or f) non-payment of any outstanding balance for services previously incurred. PCPs cannot terminate members during an acute episode of care such as hospitalizations or skilled nursing facility (SNF) stays.
Notify Blue Advantage’s Customer Service department if a member is disruptive to the practice or is abusing benefits. Document specific behaviors that are interfering with your ability to establish and maintain a positive physician-patient relationship and retain any correspondence to or from the patient.

Medical Records

Blue Advantage has adopted guidelines for the maintenance of medical records within participating physician offices that support consistent and complete documentation of each member’s medical history and treatment. Appropriate documentation is an essential component of quality care. Medical records guidelines and review procedures have been developed to comply with state, CMS and other nationally recognized standards. At a minimum, medical records must be retained for 10 years.

The Blue Advantage Quality Management Committee has established the following minimum set of guidelines for a complete patient record. We may, from time to time, review a sampling of the physician’s medical records to determine compliance with these guidelines. In addition, we will review a sampling of the physician’s medical records every three years as a component of the recredentialing process. Whenever possible, we will give the practice at least 30 days advance notice of medical record review.

Each medical record will be reviewed in relation to the following criteria:

- Medical record is organized and does not contain loose papers
- All sheets contain the patient’s name, date of service and another unique patient identifier (DOB, MRN, etc.)
- Written entries are complete and legible
- Only standard medical abbreviations are used
- Each entry is dated and signed or initialed by the person making the entry. The reviewer must be able to identify the name and professional title of the person who made the entry.
- All charts must contain the following information:
  - Patient’s identification information/demographics
  - List of allergies or a statement that the patient has reported no allergies
  - Problem list with dates of onset and resolution, including names of consulted providers, as applicable
  - Medication list, including diagnosis treated, and dates initially prescribed and discontinued, as applicable
  - Past medical history
  - Past surgical history or statement of none
  - Prevention check list, including age-appropriate immunizations, bone mass measurements and screenings for colorectal exams, mammograms, Pap smears/pelvic exams, prostate cancer exams and cardiovascular screening blood tests
  - Durable Power of Attorney for Health Care and Health Care Directive, or a statement that these documents were discussed with the patient
- Office visits document the following information:
  - Reason for the visit: chief complaint, as applicable
  - Pertinent biometrics and vital signs
  - History and physical examination pertinent to the reason for the visit
- Assessment of the patient’s health problem(s), including any medical history related to this episode of care that is not previously documented
- Plan of treatment, including testing, referrals, therapies and health education to be provided
  - All associated medical records, including specialist and/or ancillary reports, are signed and dated with any abnormalities addressed

Physicians are expected to achieve an 80 percent score, at a minimum, on the medical record reviews. Medical records of physicians scoring below this threshold will be re-audited in 180 days to ensure the documentation meets expected standards. Results of medical record reviews become part of the physician’s profile. Deficiencies in medical record documentation are addressed through the Quality Management corrective action plan process and in collaboration with the physician.

Occasionally Blue Advantage may request medical record documentation to investigate a member grievance or appeal. In this event, the practitioner should respond within the timeframe stated in the request or within 10 calendar days of the date of the request.

**Coding Support**

All reported diagnoses must be supported by medical record documentation. A diagnosis can only be coded when it is explicitly spelled out in the medical record. Diagnoses must be clear enough to be abstracted by a competent professional coder. A list of diagnoses or complaints without indication of treatment, or assessment of current disease, specific signs, symptoms, or status is inadequate and cannot be used for coding purposes. The record must contain evidence of evaluation and be linked to each diagnosis listed.

**Coding Audits**

Coding Audits are conducted by certified coders to ensure that all diagnosis codes reported by the provider of service are appropriate based on supporting medical record documentation. Determination of the type of audit to be conducted is based on reported trends or risk areas, or issues identified upon review of claims, reports or specific diagnoses.

The Coding Department discusses audit results and provides details of specific coding/documentation concerns to the physician or the physician’s group administration. In the event audit results are unfavorable, additional monitoring and a possible corrective action plan may be implemented, contingent upon the severity of the issue(s) identified.

**Physician Signature Guidelines**

CMS guidelines mandate the presence of signatures specifically for all “medical review” purposes. Records pertaining to any procedures billed to Medicare Part B are potentially subject to review by not only Blue Advantage but also other CMS contractors.

CMS allows the use of handwritten or electronic signatures.

Electronic signatures must be date and time stamped. Please note that the individual performing the service must be the provider who signs the documentation.

*See next page for more information on signature guidelines.*
Please adhere to the following guidelines to ensure that signature requirements are met:

<table>
<thead>
<tr>
<th>Description</th>
<th>Signature Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Legible full signature</td>
<td>X</td>
</tr>
<tr>
<td>2. Legible first initial and last name</td>
<td>X</td>
</tr>
<tr>
<td>3. Illegible signature over a typed or printed name</td>
<td>X</td>
</tr>
<tr>
<td>Example: John Whigg, MD</td>
<td></td>
</tr>
<tr>
<td>4. Illegible signature where letterhead, addressograph or other information on page indicates identity of signature</td>
<td>X</td>
</tr>
<tr>
<td>Example: an illegible signature appears on a medical record. The letterhead lists 3 provider names. One of the names is circled</td>
<td></td>
</tr>
<tr>
<td>5. Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by:</td>
<td>X</td>
</tr>
<tr>
<td>a. A signature log or</td>
<td></td>
</tr>
<tr>
<td>b. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>6. Illegible signature NOT over a typed/printed name and NOT on letterhead, and the documentation is unaccompanied by:</td>
<td>X</td>
</tr>
<tr>
<td>a. A signature log or</td>
<td></td>
</tr>
<tr>
<td>b. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>Example:</td>
<td></td>
</tr>
<tr>
<td>7. Initials over a typed or printed name</td>
<td>X</td>
</tr>
<tr>
<td>8. Initials NOT over a typed/printed name but accompanied by:</td>
<td>X</td>
</tr>
<tr>
<td>a. A signature log or</td>
<td></td>
</tr>
<tr>
<td>b. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>9. Initials NOT over a typed/printed name unaccompanied by:</td>
<td>X</td>
</tr>
<tr>
<td>a. A signature log or X</td>
<td></td>
</tr>
<tr>
<td>b. An attestation statement</td>
<td></td>
</tr>
<tr>
<td>10. Unsigned typed note with provider's typed name</td>
<td>X</td>
</tr>
<tr>
<td>Example: John Whigg, MD</td>
<td></td>
</tr>
<tr>
<td>11. Unsigned typed note without provider's typed/printed name</td>
<td>X</td>
</tr>
<tr>
<td>12. “Signature on file”</td>
<td>X</td>
</tr>
</tbody>
</table>
Electronic Signatures

The following are examples of acceptable electronic signatures:

- Chart “Accepted by” with provider’s name
- “Electronically signed by” with provider’s name
- “Verified by” with provider’s name
- “Reviewed by” with provider’s name
- “Released by” with provider’s name
- “Signed by” with provider’s name
- “Signed before import by” with provider’s name
- “Signed: John Smith MD”
- “Digitized signature:” Handwritten and scanned into computer
- “This is an electronically viewed report by John Smith MD”
- “Authenticated by John Smith MD”
- “Authorized by John Smith MD”
- “Digital Signature: John Smith MD”
- “Confirmed by” with provider’s name
- “Closed by” with provider’s name
- “Finalized by” with provider’s name
- “Electronically Approved by” with provider’s name
- “Signature Derived from Controlled Access Password”

The following are examples of unacceptable electronic signatures:

- Dictated but not read
- Signed but not read
- Auto-authentication
- Generated by

Record Corrections

Any correction, addition or change in any member record made more than 48 hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such. The date, time and name of the person making the correction, addition or change shall be included as well as the reason for the correction, addition or change.

Confidentiality of Medical Records

Medical records of members are confidential documents and must be treated as such to comply with state and federal laws and regulations. Providers must maintain the confidentiality of all information contained in a member’s medical record and only release such records or information: a) in accordance with the provisions in the signed Provider Agreement, b) subject to applicable laws, regulations or orders of any court of law, c) as necessary, to other providers treating a member, or d) with the written consent of the member.
**Availability and Transfer of Medical Records**

When members change PCPs, they may request a transfer of medical records or copies of medical records. These records must be forwarded to the member or to the new provider within 10 business days from receipt of the request.

Participating physicians and other providers, including facilities, are required to comply with Blue Advantage’s Quality Improvement and Utilization Management activities. In many instances, this is accomplished by making medical records available to the health plan or its authorized agent. In addition, authorized representatives from CMS are allowed access to patient records of Blue Advantage members for specific purposes.

To facilitate this process, all members sign a release of medical information as part of their enrollment process. This release is in effect for the duration of their status as a Blue Advantage member:

> I authorize any health professional or organization to provide to Blue Advantage or any of its affiliates, information related to medical history, care, treatment or consultation provided to me for the purpose of administering or coordinating the Medicare program.

This release authorizes Blue Advantage access to members’ medical records and to make copies as necessary. Blue Advantage will request, access and, if applicable, copy only the section or sections of the medical record that is necessary to make a coverage determination, pay claims and carry out other health plan benefit administration and quality management activities.

**Transfer of Information Between Providers**

During the office orientation, Blue Advantage will educate network providers and their office staff on the following to promote continuity of care for Blue Advantage members:

**Primary Care Providers:** When a PCP refers a patient to a specialist, the PCP should forward relevant notes, X-rays, reports or other medical records to the specialist prior to the patient’s scheduled appointment.

**Specialists:** Specialists should report preliminary diagnosis and treatment plans to the patient’s PCP within two weeks from the date of the first office visit. The specialist should provide the PCP with a detailed patient summary report within two weeks after the completion of the evaluation or treatment and within two weeks of each subsequent encounter.

**Confidentiality:** Participating providers should exercise reasonable care to ensure that medical record information transfers are performed in a confidential, timely and accurate manner that is consistent with applicable state and federal laws.
Terminating from Blue Advantage

While Blue Advantage makes reasonable efforts to resolve provider issues, contracted providers may voluntarily terminate their participation in the Blue Advantage network by providing at least 90 days advance written notice to Blue Advantage.

Upon receiving a contract termination notice for a PCP or a specialist, Blue Advantage will close the PCP’s panel to new members and notify affected members of the forthcoming contract termination. Blue Advantage will provide assistance, as needed, to transition care to another participating PCP or specialist. The resigning provider is responsible for the continued care of Blue Advantage patients during the 90-day notification period.

Blue Advantage may terminate the participation of an individual provider for cause. Blue Advantage gives notice in accordance with the terms of the Participation Agreement.

Changes in Your Practice

You must notify the Blue Advantage Credentialing and Contracting Department in writing if you have any changes within your practice. A form entitled “Provider Update Request Form” can be completed via our Blue Advantage Provider Portal. The form is also provided in the back of the manual and can be faxed, emailed and/or mailed. Information that needs to be communicated includes, but is not limited to:

- Change of address, phone, fax or billing location
- Change in hours of operation

To report a change in your tax ID number, use the Blue Cross Notice of Tax Identification Number (TIN) Change Form. To request network termination, use the Blue Cross Request for Termination Form. These forms are available online at www.bcbsla.com/providers > Forms for Providers.

We will advise you if additional information is necessary to process your request.

Physician Satisfaction Survey

Blue Advantage will conduct a physician satisfaction survey. The results of this survey will be used by the health plan to provide resources, information and systems in ways to assist physicians to deliver the highest quality of care. You will receive the survey at your office. Your responses are confidential; only aggregate data is reported to Blue Advantage. However, should you wish to comment further on issues, on the overall survey, or should you wish to identify yourself, please do so in the comment section of the survey.
Medical Management

Provider Quick Reference Guide

For help in determining whether a service requires a prior-authorization or notification, please refer to the Provider Quick Reference Guide and the Durable Medical Equipment/Orthotics & Prosthetics list, available on the Blue Advantage Provider Portal. These lists are updated periodically throughout the year.

Benefit Determinations

Providers with questions about a specific benefit or “covered services” should direct their queries to the Blue Advantage Medical Management department. The Medical Management department is responsible for administering authorizations, medical necessity determinations and monitoring the appropriateness and efficiency of services rendered. Certain services require an authorization to confirm that the member’s PCP and Blue Advantage has approved the member’s specialty care services. Blue Advantage utilizes the following resources for benefit and medical necessity determinations:

- Member’s Evidence of Coverage (EOC) and Summary of Benefits
- Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Medicare Managed Care Manuals
- InterQual®
- Hayes Health Technology Website
- CMS Designated Medical Compendia
- AIM Specialty Health, a radiology benefits management vendor

Patient-specific information is needed by Blue Advantage to determine the medical necessity and member’s benefit for a requested procedure. This information includes:

- ICD-10 diagnosis and procedure codes, as applicable
- Prior procedures/testing/treatments that have been tried and failed (include supporting documentation, photos, if applicable)
- Plan of treatment
- Requested service description (include CPT® and HCPCS codes)
- Expected outcome

If the request is for out-of-network services, also include:

- The reason the member needs to go out-of-network
- The name of network providers who have been consulted
- The medical records from the requesting physician and consulting physicians

Please send all requests for benefit determinations to Blue Advantage Correspondence at the address or fax noted in the front of the manual or call the Medical Management Department to make a request.

For information regarding members’ benefit plans and coverage, you may consult the Summary of Benefits and Evidence of Coverage documents placed on our website at www.bcbsla.com/blueadvantage.

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Prior Authorizations and Notifications

Prior authorization is the process of collecting information in advance of authorizing the non-emergency use of facilities, diagnostic testing and other services before care is provided.

To request a prior authorization of items or services, providers may contact Medical Management by phone or fax. The contact information is in the Plan Information Contact List located in the front of this manual. The phones are forwarded to a secure voice mail system during non-business hours. The fax is available 24 hours a day, seven days a week. Please allow up to 14 days for a standard decision and 72 hours for an expedited decision to be rendered, although decisions will be made as expeditiously as the member’s health condition requires.

The prior authorization process permits advanced eligibility verification, determination of coverage and communication with the requesting physician or member. Prior authorization also allows Blue Advantage to identify members for pre-service discharge planning and case management.

Prior authorizations are accepted by telephone or fax, with a review conducted by a representative of the Medical Management department, Medical Director or Board-Certified Specialist. In each case, the review ensures that coverage for the services are included in the individual’s benefit plan, that services are provided at the most appropriate level of care and site, and that the services are medically necessary. Only the Medical Director (or clinical reviewer designee) may determine a denial of services based on medical necessity.

Outpatient surgical procedures requiring prior authorization: Providers must contact Medical Management at least 14 days prior to the procedure.

Elective hospital admissions: Providers must contact Medical Management at least 14 days prior to an elective admission. If a previously elective admission is canceled, Blue Advantage Medical Management must be notified of that cancellation and the reschedule date, if applicable.

A new authorization may be required if the authorized health service requested has not been delivered within the time frame specified in the authorization.

Blue Advantage’s decision regarding an authorization is a coverage determination. Blue Advantage’s decision is never intended to limit, restrict or interfere with the physician’s medical judgment. In all cases, decisions regarding treatment continuation or termination, treatment alternatives or the provision of medical services are between physician and patient.

Notification is the act of providing notice or alerting Blue Advantage of a particular service provided to a Blue Advantage member. The notification process permits eligibility verification, communication with the PCP and member identifies members for concurrent review, pre-service discharge planning and case management. The Blue Advantage Medical Management department will accept this verbal notification from the scheduling specialist, the facility or the primary care provider.
Notification Requirements

Emergency hospital admissions: Providers must contact Medical Management within one business day. If an admission changes from observation to inpatient, the provider must notify Medical Management within one business day.

Providers can report emergent hospital admissions to Medical Management. The contact information is in the Plan Information Contact List located in the front of this manual. The phones are forwarded to secure a voice mail system during non-business hours. The fax is available 24 hours a day, seven days a week. Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number does not guarantee payment. The notification process serves to:

- Confirm the admission is authorized by the primary care physician, if applicable
- Verify member eligibility
- Screen for coverage/benefit exclusions
- Identify if the facility is a Blue Advantage contracted facility
- Notify the appropriate Blue Advantage Case Manager of the admission (hospital) to begin review of continued stay appropriateness and early identification of potential discharge needs

Upon issuing a reference number for a hospital admission, providers are instructed to submit clinical documentation to Blue Advantage within one business day of admission to complete the notification process and receive an authorization for payment. The clinical information provided enables Blue Advantage Case Management to initiate the concurrent review process (see the Initial, Concurrent Review and Discharge Planning Section).

Inpatient admissions and outpatient surgical procedures that have received authorization are eligible for payment by Blue Advantage as long as all other requirements have been met. Blue Advantage is not obligated to pay claims on an authorization number for the following situations:

- Persons who are not Blue Advantage members at the time of service.
- Persons who fail to meet other eligibility criteria.
- Persons who receive care determined not to be medically necessary.
- Claims that may be denied based on claims-editing logic.

Providers who are denied payment because notification/prior authorization is lacking may not bill the member. Provider pay disputes should be submitted in writing. Your request should outline the basis for the dispute and should include documents supporting your position. Please send your written claims dispute requests with all supporting documentation to Blue Advantage Correspondence. The address is located in the front of this manual.
Radiation Oncology Program

The Radiation Oncology Program reviews certain treatment plans against clinical appropriateness criteria to help ensure that care aligns with established evidence based medicine. To request review of treatment plans, providers should contact AIM Specialty Health (AIM) for review for the radiation therapy modalities and services. Information on how to contact AIM for an authorization is available in the front on this manual. See the Quick Reference Guide for the list of services that must be pre-service reviewed by AIM.

The program design includes both prospective and retrospective, for up to two days after the date of service, case reviews for the services requiring authorizations. The goal is for physicians to obtain pre-service review of their requests; however, there are circumstances that may prevent the physician from submitting a case pre-service when a retrospective review will occur.

For treatment plans that are scheduled to begin on or after January 1, 2016, all providers must contact AIM to obtain pre-service review for non-emergency, outpatient radiation therapy modalities.

Radiation therapy performed as part of an inpatient admission is not part of this AIM program.

*Voluntary Notification for 3-D Conformal Radiation Therapy (EBRT)

For 3-D Conformal Therapy (EBRT), pre-service review is required only for procedures involving bone metastases and breast cancer. Additionally, Blue Advantage is requesting that ordering providers contact AIM to review all other 3-D conformal therapy requests on a voluntary basis.

Initial, Concurrent Review and Discharge Planning

Inpatient and concurrent review encompasses those aspects of patient care management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. All reviews are conducted by phone or via fax utilizing InterQual® medical necessity review criteria and Medicare guidelines.

The concurrent review process includes the following activities:

- Collection of necessary information from providers and facilities concerning the care provided to members.
- Assessment of the clinical condition and ongoing medical services and treatments to determine benefit coverage and medical necessity.
- Identification of continuing care needs to facilitate discharge to the appropriate setting.
- Discharge planning and coordination.

To facilitate initial and concurrent review and discharge planning, facilities are required to perform the following activities:

- Provide clinical information to Blue Advantage Case Management upon one business day of admission to obtain an initial authorization.
- Provide updated clinical information as requested by Blue Advantage Case Management within one business day of request to obtain authorization for days beyond the initial length-of-stay authorization.
- Provide anticipated discharge dates to Blue Advantage Case Management to issue final length-of-stay authorization for claims payment and ensure effective and appropriate coordination of after-care services.
Using InterQual® medical necessity review criteria and Medicare guidelines, the case managers perform prospective review for requests of extended-care facility (rehabilitation hospital, long-term care hospital (LTAC), skilled nursing facility) services, home health services, and concurrent review for continued care reviews for acute hospital, rehabilitation hospital, LTAC, skilled nursing facility, home health, and outpatient services to determine if the case meets criteria for continued authorization. Retrospective requests for review of inpatient services may be considered for good cause.

When a case manager’s review demonstrates the criteria are not met, the case is referred to a Blue Advantage Medical Director for review.

The case manager will authorize the services based on whether the services meet all of the following conditions:

- The services are appropriate given the symptoms and member’s medical history and are consistent with the diagnosis. “Appropriate” means the type, level and duration of services and setting are necessary to provide safe and adequate care and treatment;
- The services are rendered in accordance with Medicare and professionally recognized standards;
- The services are not generally regarded as experimental or unproven by recognized medical professionals or appropriate governmental agencies; and
- The services are permitted by the licensing statutes that apply to the provider who renders the services.

If a member’s condition is not appropriate for admission according to the criteria or the member’s condition has improved or stabilized to the point where acute inpatient care is no longer necessary, the case manager helps coordinate arrangements to transition the member to an alternative level of care. The case manager will communicate with the physician(s), member, member’s family and support staff regarding the member’s future needs. Once the physician has communicated what is needed to facilitate the discharge of the member, the case manager coordinates the elements including transfer to other facilities, ordering durable medical equipment (DME), home health care and other post-hospitalization services.

Complex cases, which require the advice of the medical director, will be referred for immediate review. When medically appropriate, observation care is an option for patients whose problems are reasonably expected to be resolved within 24 to 48 hours. Observation care includes ongoing short-term treatment, assessment and reassessment that is provided while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Observation services must also be reasonable and necessary to be covered. Notification is not required for observation services that are 48 hours or less. Hospitals must notify Blue Advantage Medical Management of members with observation stays of greater than 48 hours.
Notice of Discharge from an Inpatient Facility

The Important Message from Medicare (IM) is an existing statutorily required notice designed to inform Medicare beneficiaries that their covered hospital care is ending. The physician who is responsible for the member’s inpatient hospital care must make the decision that discharge is appropriate. The IM must be given to the member within two days of discharge.

The Notice of Medicare Non-Coverage (NOMNC) is issued to Medicare beneficiaries notifying them that their skilled services, home health care or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending. Per CMS guidelines, the NOMNC must be given to the member and/or their identified representative a minimum of two days prior to discharge even if they agree the service should end. A signed NOMNC must be faxed to Blue Advantage Medical Management at 1-877-528-5816.

Both of these forms are located in the Forms/Sample section of this manual.

The member’s appeal rights are included in both the IM and NOMNC forms.

Network and Out-of-network Providers

Blue Advantage strives to provide a comprehensive network of providers to meet our members’ healthcare needs. Participating physicians help ensure the affordability and success of their patients’ healthcare by referring them to participating network providers. In rare instances, a patient may have a medical need for a non-emergent service that cannot be met by a network provider. If the PCP is unable to refer to a network provider, prior-authorization from the Medical Management department will be required before the patient can be referred to a non-participating provider.

If a PCP wishes to refer to an out-of-network (OON) specialist, contact the Blue Advantage Medical Management department at the number in the front of this manual. Medical Management will perform the following activities:

- Confirm the provider is OON.
- If OON, search the provider directory to determine if there is an in network specialist, of the same type as being requested, within a 20-mile radius of the member’s residence. If there is not, the OON request is approved.
- If there is an in-network specialist, Medical Management requests the PCP’s office to withdraw the request for the OON specialist and redirect to an in-network specialist.
- If the PCP does not want to redirect, the PCP is asked to send in clinical information to Medical Management to support the need for the OON specialist.
- If clinical information is sent, it is reviewed against Transition of Services criteria. If it does not meet criteria, a denial letter is sent to the member and PCP that includes appeal rights.

Transition of Services criteria:

- With the exception of transplant services, the services requested are not available from contracted providers within a 20-mile radius.
- Dialysis, until the member can be transitioned to a participating provider or up to a period of 60 days from the effective date for new members or from the time the member’s provider terminated from the network.
- Newly-diagnosed or relapsed cancer in the midst of a course of treatment (radiation or chemotherapy).
• Members who are a recipient of an organ or bone marrow transplant, and are within a year post transplant.
• Current hospital confinement.
• A terminal illness, for the length of the terminal illness.
• Performance of a scheduled surgery or other procedure that has been authorized by the Plan, as part of a documented course of treatment and is scheduled to occur within 30 days of the provider’s contract termination date or the effective date of coverage for a new member.
• A pregnancy in the second or third trimester of pregnancy on the member’s effective date and the immediate post-partum period.

Non-emergent, out-of-network services will not qualify for coverage unless they are authorized prior to services being rendered by Blue Advantage’s Medical Management department.

**Initial Organizational Determination (IOD)**

Whenever a member contacts Blue Advantage to request a service, the request indicates that the member believes that Blue Advantage should provide or pay for the service. Thus, the request constitutes a request for a determination and Blue Advantage’s response to the request constitutes an organization determination. However, if a provider declines to give a service that a member has requested or offers alternative services, this is not an organization determination (the provider is making a treatment decision). In this situation, the member must contact Blue Advantage to request an organization determination for the service in question or the provider may request the organization determination on the member’s behalf.

When there is a disagreement with a practitioner’s decision to deny a service or a course of treatment, in whole or in part, the member has a right to request and receive an organization determination from Blue Advantage regarding the services or treatment being requested. Blue Advantage is required to make an independent decision in these matters and will request medical records in order to make that decision. All parties will be notified in writing of the Plan’s decision.
Adverse Initial Organizational Determination Process

An adverse determination is a decision by the Plan or its designee, that an admission, availability of care, continued stay or other healthcare service has been reviewed and, based upon the information provided, does not meet the Plan’s requirements for coverage. These requirements include medical appropriateness and necessity, appropriate healthcare setting/level of care or quality and effectiveness of care. As a result of not meeting these requirements, the coverage for the requested service is subsequently denied or reduced. Blue Advantage provides an appeal process for members in the event of an adverse determination.

Adverse determinations of requested services, made in the course of the review process are communicated verbally or via fax to the requestor within one business day from when the determination was made. This communication is confirmed in writing via the Integrated Denial Notice (IDN) within three days of the oral communication. A copy of the Integrated Denial Notice is included in this manual in the “Forms” section. This notification is sent to the patient or responsible party, the physician and facility (if applicable). The reason(s) for the adverse determination of requested services, available alternatives and the appeal rights and procedures are included in the notices of denial. Blue Advantage members must receive this determination within 14 days of service request, unless an expedited determination is necessary. Other levels of the members’ appeal process are addressed in the Blue Advantage Evidence of Coverage.

Expedited Member Appeals

Expedited appeals for requested services pertain to those services in which the standard appeal time period (30 days) could seriously jeopardize the member’s life, physical or mental health or the member’s ability to regain the maximum function. Blue Advantage must resolve an expedited review within 72 hours or as expeditiously as the member’s physical or mental health requires. An expedited appeal can be made by the member or provider on behalf of the member.

Health Risk Assessments

Blue Advantage sends a Health Risk Assessments (HRA) to each member upon confirmation of the member’s effective date from CMS. These HRAs are analyzed in order to identify those members who have complex or serious medical conditions. The information gathered through the HRA is forwarded to the PCP for inclusion in the patient’s record. The PCP is expected to conduct an assessment, establish and implement treatment plans appropriate to the condition and monitor each case on an ongoing basis.
**Clinical Trials**

There are certain requirements for Medicare coverage of clinical trials. Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage (MA) plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials. Blue Advantage pays the enrollee the difference between original Medicare cost-sharing incurred for qualified clinical trial items and services and Blue Advantage’s in-network cost-sharing for the same category of items and services. When a member is in a clinical trial, the member may stay enrolled in Blue Advantage and continue to get the rest of their care that is unrelated to the clinical trial through Blue Advantage. In addition, if plan guidelines are followed, a member may be made whole financially for the difference between the original Medicare member cost share and the Blue Advantage cost share for identical benefits. Please supply documentation such as the Medicare provider remittance notice or the member’s Medicare Summary Notice along with the claim as this shows the amount of member cost share incurred.

If you have a patient that you intend to refer for a clinical trial, please notify Blue Advantage’s Medical Management Department prior to enrolling the member in the clinical trial or providing service related to the clinical trial.

Modifiers Q0 and Q1 should be billed, if applicable.

**Behavioral Health and Substance Abuse Services**

Blue Advantage has partnered with New Directions for their expertise in the provision of behavioral health services. To arrange for care, the physician or member may call New Directions. The contact information is in the Plan Information Contact List located in the front of this manual. No referral is needed; however, the member must be directed and seen by a provider within the Blue Advantage network to receive covered services.

Participating providers include:

- Professional Counselors and Psychologists
- Psychiatrists
- Psychiatric Nurses and Social Workers
- Facilities for inpatient and outpatient care including rehabilitation

New Directions’ team of behavioral health professionals is available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.

**Case Management**

As a partner in managing the health needs of our members, Blue Advantage offers a variety of case management services that are available through coordination with the PCP or Plan staff. Members identified as high risk are also outreached to. These services are available at no charge to all members not enrolled in a hospice program, or residing in a long-term care facility and who agree to case management. Our programs focus on improving our members’ health status and quality of life, access to community resources and reduction of unnecessary costs for CMS, our members and the plan. Our physician-led interdisciplinary team includes a health outreach specialist, nurse case managers, social work, behavioral health specialists and clinical pharmacists.
Emergency Care

Blue Advantage advises members to go to the nearest hospital emergency room if they believe their health is in serious danger. A medical emergency may include severe pain, a serious injury or illness or a medical condition that is rapidly getting worse.

The Blue Advantage Medical Management department MUST be notified of a hospital admission within 24 hours or by the end of the next business day. If an admission through the emergency room is made by a doctor other than the PCP, the PCP should be notified within 24 hours or the next business day following the admission.

Ambulance service for transportation to the hospital is a covered benefit for members in emergencies only. In such an emergency, 911 or another local emergency number should be called.

Out-of-area Care/Urgent Care

Urgent care refers to care delivered when members need medical attention right away for an unforeseen illness or injury, and it is not reasonable, given the situation, for members to get medical care from their PCPs or other plan providers. Members (or their authorized representatives) are instructed to contact their PCPs as soon as possible. When urgent care is needed in the service area, members should contact their PCPs to direct their care. Notification is required for all urgent out-of-area hospital admissions. You or your patient (or your patient’s representative) may satisfy this obligation by contacting a representative of the Medical Management department.

Non-participating Hospitalization

Whenever we are advised that a Blue Advantage member has been hospitalized on an emergency basis in a non-participating facility, we will notify the member’s PCP. If the member calls the PCP, then the PCP is required to notify Blue Advantage within one business day. The patient may be transferred to a Blue Advantage participating facility when the patient’s condition has stabilized. These services require authorization by the Medical Management department.

Dialysis Patients

For those providers who initiate hemodialysis for ESRPD patients, CMS requires dialysis providers to enter the CMS-2728 Form into the CMS established and governed system, CROWNWeb. Once the information is entered into the system, the provider should print out the form, sign it, have the member sign it and mail it to the Social Security Administration. The website for CROWNWeb is www.projectcrownweb.org.

Institutionalized Patients

When a member is in need of long-term custodial care, the member and family can choose any facility within our service area to reside. Please note that the member is going to that facility in a private pay capacity, as neither Blue Advantage nor Traditional Medicare cover the cost of custodial care. Blue Advantage needs to be informed of this action either by the member, family member or the PCP. The individual can remain a member of Blue Advantage; however, the member must continue to abide by plan rules for any care requires while living in the facility. For example, non-custodial care must be directed by an in-network PCP. Blue Advantage providers must be utilized to receive most covered services.
The PCP has various options to manage a custodial patient, which include:

1. If practical, the patient can continue to be seen in the PCP’s office.
2. The PCP can continue to see and treat the patient in the facility.
3. The Medical Director of the facility may oversee the patient’s care on behalf of the PCP. Good communication needs to be established between the PCP and the Medical Director for the continuation of coordinated care.

**New Technologies**

Blue Advantage advocates the physician’s freedom to communicate with patients regarding available treatment options, including medication alternatives, regardless of benefit coverage.

Blue Advantage also has a process for accepting requests from physicians to consider new and emerging technologies and criteria. Such requests should be submitted with a letter outlining the medical necessity of the procedure or criteria and any medical documentation on the subject. Blue Advantage will determine if the new treatment or procedure is a covered benefit.

Please note that new and emerging technology must be a covered benefit under traditional Medicare before it can be approved for Blue Advantage members.

Requests for coverage of a new or emerging technology should be submitted in writing, prior to providing or securing the service, to Blue Advantage Correspondence. The address and fax number are located in the front of this manual.

**Outpatient Laboratory Tests**

Blue Advantage network providers have the following options for lab work:

- Perform lab work in the office in accordance with the level of Clinical Laboratory Improvement Amendments (CLIA) certification
- Draw labs in the office and send specimens to one of our participating lab facilities identified in our Provider Directory
- Send Blue Advantage members to a Blue Advantage network reference laboratory. The contact information is in the Plan Information Contact List located in the front of this manual.
Transportation Benefit

Blue Advantage provides non-emergency transport services, through Medical Transportation Management (MTM) as an additional benefit to Blue Advantage members. A specific, limited amount of one way non-emergent trips to in-network providers for covered healthcare services or supplies are covered contingent on the region/plan the member selects. The transportation benefit may be used for any approved benefit destination such as physician visits, trips to the pharmacy, etc. The benefit cannot be used for non-Blue Advantage benefit-related trips such as visiting a friend at a nursing home or hospital. The trip must be scheduled at least two business days in advance. MTM is not expected to arrange transportation with less than two business days’ notice. The transportation benefit is not meant to be used as a substitute for emergency transportation such as an ambulance.

Members may schedule their own non-emergent transportation services. The contact information is in the Plan Information Contact List located in the front of this manual. They need to provide:

- Their name and Blue Advantage member ID number (located on their Blue Advantage ID card)
- The address and ZIP code of the location where they need to be picked up
- The name, address, ZIP code and phone number of their destination

When scheduling transportation, they will be asked a series of questions that will help MTM determine the most appropriate mode of transportation for their needs. If the driver does not show, one should call the number on the card given to the member by the driver. If there is no response, contact MTM at to explain the situation and that the member needs immediate assistance.

Non-emergency transport services are available only in the following areas:

- Baton Rouge Area: Ascension, East Baton Rouge, Livingston, St. Helena and West Baton Rouge
- Greater New Orleans Area: Jefferson, Orleans, St. Charles, St. James and St. John the Baptist

Plan consists of six one-way trips.
Pharmacy Management

Pharmacy Network

Blue Advantage provides coverage for prescription medications and members may have their prescriptions filled through a wide network of pharmacies, including mail order. Please refer your Blue Advantage patients to their provider directory for a comprehensive list of participating pharmacies.

Medicare Part D Formulary

Blue Advantage utilizes a formulary (list of covered drugs) for Medicare Part D coverage. For a specific list of covered drugs, please refer to the Blue Advantage formulary, which is available in print and also on our website. The Medicare Modernization Act of 1996 specifically prohibits certain medications from being covered under Medicare Part D; therefore, the following types of drugs are specifically excluded from coverage for Blue Advantage members:

- Drugs used for anorexia, weight loss or weight gain
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Non-prescription (over-the-counter) drugs

Blue Advantage has made arrangements with its pharmacy benefit manager, Express Scripts, Inc., to perform certain Part D functions such as Coverage Determinations and Appeals. Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, defined by CMS as Coverage Determinations. Drugs with these requirements are noted in the Blue Advantage published formulary. Request for coverage determination may be made by phone, fax, mail or online. Instructions on each process are defined further in this section of this manual.

Medicare Part D Benefit

<table>
<thead>
<tr>
<th>Drug Category (Tier)</th>
<th>The Blue Advantage Part D formulary is organized into five drug tiers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Preferred Generic</td>
<td>Members pay a copayment for drugs in Tiers 1 through 4, and a coinsurance for drugs in Tier 5. In general, the lower the drug tier, the lower the member’s cost share.</td>
</tr>
<tr>
<td>Tier 2 – Generic</td>
<td>There are three coverage phases under the Medicare Part D benefit: 1) the Initial Coverage Phase (ICP); 2) the Coverage Gap Phase (commonly referred to as the “donut hole”); and 3) Catastrophic Coverage Phase. During the ICP, a member pays part of the cost of a covered Part D drug, such as a deductible, if applicable, and a copayment or coinsurance and Blue Advantage pays the remainder. The member remains in the ICP until the total drug costs reach a predetermined dollar amount established by CMS, also known as the Initial Coverage Limit (ICL), which is $3,700 for the 2017 plan year. Once members reach the $3,700 limit, they move to the Coverage Gap Phase, also known as the “donut hole.” Members receive a discount off the cost of brand and generic drugs while in the coverage gap; the amount of the discount is predetermined by CMS each year. For 2017, there is a $3 copay for all Tier 1</td>
</tr>
</tbody>
</table>
Preferred Generic drugs and a $12 copay for all Tier 2 Generic drugs, or 51 percent of the costs, whichever is lower. For brand name drugs, members pay 40 percent of the price (plus a portion of the dispensing fee). Some members may have coverage of generic drugs while in the Coverage Gap Phase, depending upon their Part D benefit design.

Members remain in the Coverage Gap Phase until they have paid an Out-Of-Pocket Amount equal to a pre-determined dollar amount as established annually by CMS. The amount for 2017 is $4,950. After reaching the out-of-pocket amount, members move into the Catastrophic Coverage Phase. In the Catastrophic Coverage Phase, members are responsible for paying a small copayment or coinsurance, as established annually by CMS, for covered Part D drugs and Blue Advantage pays the remainder of the drug cost.

**Medicare Covered Drugs (also called Medicare Part B Drugs)**

Drugs covered under Original Medicare are also covered for Blue Advantage members. “Drugs” include substances that are naturally present in the body, such as blood clotting factors. There is no benefit limit on these drugs and their cost does not count against the member’s outpatient prescription drug benefit. Certain Part B drugs require prior authorization from Blue Advantage.

The following drugs are Medicare covered drugs:

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services
- Drugs used with durable medical equipment (such as nebulizers) that were authorized by Blue Advantage
- Clotting factors self-administered by a member that has hemophilia
- Immunosuppressive drugs, if the member had an organ transplant that were covered by Medicare
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and the member cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs, once only available in an injectable form, that were covered by Medicare
- Certain oral anti-nausea drugs used as a full replacement for intravenous treatment and administered within 48 hours of cancer treatment
- Insulin when administered via insulin pump
- Erythropoietin if the member has end-stage renal disease, receives home/outpatient dialysis and needs this drug to treat anemia

**Part D and Part B Drugs Requiring Prior Authorization**

Requests for coverage of drugs are routed differently depending on who is furnishing and billing for the drug (pharmacy vs. medical). Please review the information and educate office staff as needed to ensure that coverage requests are submitted through the proper channels. This helps prevent situations where a drug was authorized through one channel but billed through another channel and subsequently denied for no authorization in place.
Part D Drugs Billed Through Pharmacy – Part D Prescription Drug Coverage Form

You have several methods to choose from when requesting a coverage determination for your Blue Advantage patient. You can reach us by phone, fax, mail or online. Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Blue Advantage published formulary. These are all examples of coverage determinations. To request a coverage determination for a Part D drug, you can contact Express Scripts, Inc. The contact information is in the Plan Information Contact List located in the front of this manual. You can also complete the Part D Prescription Drug Coverage Determination Request Form and return it to the contact information listed in the Plan Information Contact List located in the front of this manual. The form is available for download from the Blue Advantage Provider Portal under the Forms link or you can call the plan and ask that we fax the form to your office. You can also access an electronic version of the form from the Blue Advantage Provider Portal.

To submit an electronic request for a coverage determination for a Part D drug, online tools are available to provide real-time responses. There are three options for prescribers based on their practice preferences. The first two options are Web-based portals; see the URL links below. Prescribers will simply need internet access to be able to submit requests electronically. You must first register as a user on each portal. Once registered with your selected vendor, covermymeds or expressPAth you will see the step-by-step process for submitting coverage determination requests. The required information you enter when submitting an electronic request is identical to what you would need to provide via phone or fax.

www.covermymeds.com
www.express-path.com

Electronic Prior Authorization (ePA) is also available within the practice EMR software today (if ePA capabilities are not available in your practice software, you may request the capability from your software vendor). In this application, the prescriber can be alerted that a prior authorization is required when submitting an electronic prescription. At this time the prescriber is able to initiate a coverage determination request from within the practice software, and does not need to move to one of the Web-based portals mentioned above.

Some drugs require a coverage determination for the purpose of determining whether they should be covered under Part D or Part B for the specific situation, based on Medicare rules. You may be asked to provide information regarding diagnosis or other pertinent information in order to facilitate the determination.

To request a Part D Prescription Drug Coverage Determination Form, please contact Express Scripts, Inc. The contact information is in the Plan Information Contact List located in the front of this manual.
Part B Drugs Billed Through Medical – Part B Drug Prior Authorization Request Form

Certain Part B drugs billed through the medical benefit are subject to prior authorization. Prior authorization requests may be made by calling Blue Advantage Medical Management. The contact information is in the Plan Information Contact List located in the front of this manual. Requests may also be made by completing the Part B Drug Prior Authorization Request Form or one of the drug-specific forms found under the Forms section of the Blue Advantage Provider Portal. Completed forms should be faxed or mailed to Blue Advantage Medical Management at the fax number/address located at the top of the form.

Opioid Overutilization Monitoring Program

CMS mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review (DUR) programs to address overutilization of medications; specifically to address opioid overutilization among its Part D enrollees. CMS recognizes “overutilization” as filling of multiple prescriptions written by different prescribers at different pharmacies for the same or therapeutically equivalent drugs in excess of all medically-accepted norms of dosing. For more information about the Blue Advantage opioid overutilization monitoring program, please refer to the Blue Advantage Provider Portal and click the “2016 Pharmacy Benefit Resources” link, under the “2016 Guides and Resources” heading.

Part D Payment for Drugs for Beneficiaries Enrolled in Hospice

CMS requires that Part D sponsors place beneficiary-level prior authorization requirements on four categories of drugs for patients enrolled in hospice, to prevent hospice-related drugs from paying under Part D. These categories include analgesics, antiemetics, laxatives and anxiolytics. For members enrolled in hospice, these drugs will not pay under Part D, unless the hospice provider attests that the drug is unrelated to the terminal illness and related conditions. If the drug is deemed to be unrelated to the terminal illness and related conditions, an authorization will be placed into the pharmacy claims system to allow the drug to pay under Part D. Otherwise members will be directed to obtain the medicine from the hospice provider.

Payment for Drugs for Beneficiaries with ESRD

CMS requires that Part D sponsors utilize point-of-sale edits to prevent ESRD-related drugs from paying under Part D. If a member has an ESRD flag, drugs that are considered by CMS to be always related to ESRD will not pay under Part D. Members will be directed to obtain the medicine from their dialysis facility.
Medication Therapy Management Program (MTMP)

The Blue Advantage MTMP is a patient-centric program aimed at improving medication use and adherence, reducing the risk of adverse events and helping patients who have difficulty paying for medicines find lower-cost therapeutically appropriate medications or resources to help pay for medications. Certain members who have chronic diseases, take multiple medications and have high cost for medicines are enrolled in the program. We provide telephonic comprehensive medication reviews (CMR) as well as targeted medication reviews (TMR) to help identify and resolve medication related problems. Our program complements the care patients receive from their physicians, and does not interfere with the doctor-patient relationship. We have found that our members are very appreciative of the program. For more information about the Blue Advantage MTMP, please refer to the Blue Advantage Provider Portal and click on the “Pharmacy Benefit Resources” link, under the “2016 Guides and Resources” heading.

Online Prescription Drug Coverage Determination for All Providers

A prescribing provider can submit a prescription drug coverage determination request online through the Blue Advantage Provider Portal. There are a variety of reasons in which a coverage determination may be needed. For example, a request for coverage of a non-formulary drug, tier exceptions, step therapy, etc. This request goes directly to the prior authorization department. A provider can also submit a request for a redetermination (appeal) for a Part D prescription drug online. See the Pharmacy Management Section of this manual for additional information regarding prior authorization for Part D and Part B covered drugs.

New for January 2019 – Part D Prescriber Enrollment Update

If you are a physician or other eligible professional who writes prescription for Part D drugs, CMS regulations now require you to be enrolled in Medicare as an approved status. Initially, CMS announced the enforcement date would begin February 1, 2017. However, recent communications released by CMS states the full enforcement of the Part D Enrollment Requirement has been delayed to January 1, 2019.

CMS is implementing a multifaceted approach to ensure enforcement of the enrollment requirement by January 1, 2019. Leading up to the full enforcement date, CMS will continue to assert efforts to increase prescriber enrollment.

Although the full enforcement is January 2019, CMS strongly recommends that Part D drug prescribers enroll now.

For more information, please visit CMS’ website (www.cms.gov) or email providerenrollment@cms.hhs.gov.
Billing Guidelines

Claims and Encounter Data Submission

Claims and encounter data (for capitated providers) must be submitted using standard Medicare guidelines. Blue Advantage accepts the CMS-1500 and UB-04 forms and electronically submitted claims from Change Healthcare.

Contracted providers should seek electronic claims solutions as indicated by their Blue Advantage contract. If providers must bill on paper they should follow standard CMS claims submission requirements including submission of the Blue Advantage Member ID with leading zeros and NPI in the appropriate claim form fields.

The provider is responsible for ensuring accurate and complete data for submission. The provider is also responsible for any request made on their behalf by the staff personnel. Claims are not accepted via fax. When filing claims for secondary coverage please be sure to include the Explanation of Benefits from the primary insurer or the claim will be denied.

Blue Advantage processes all clean claims within the 30-day CMS-required standards. Status checks can be performed via our Blue Advantage Provider Portal. Since Blue Advantage permits submission of the claims for up to 12 months from the date of service, it is not necessary to establish short auto claims submission refiling cycle.

Not all claims for Blue Advantage members are filed directly to the Blue Advantage Administration office. The following should be filed directly to the vendor:

- Routine dental services are filed to United Concordia Dental
- Routine eye exams and eyewear to Davis Vision

Contact information for the above vendors is in the Plan Information Contact List located in the front of this manual.

Partial Hospitalization for Psychiatry (PHP)

Medicare changed the billing requirements for PHP effective July 1, 2016. Previously we were able to bill a recurring monthly claim. Starting July 1, 2016, Medicare requires claims to have a span of no longer than seven days and must have no less than 20 hours of therapy within those days.

Electronic Claims

Electronic claims require the same information as paper; however, electronic submission of claims dramatically improves the exchange of information and the acceptance rate of claims while reducing opportunities for error as well as decreasing the turnaround time for claims payment. These factors combine to reduce a provider’s overall administrative costs. Blue Advantage accepts initial claims submissions electronically through Change Healthcare (Blue Advantage payor identification of 84555). In addition, 84555 is the new payor identification that Change Healthcare has assigned for claims submission and receipt of the 835 ERA. All 27X transactions must be submitted to Change Healthcare using the payor identification BCLAM.
Claims filed electronically are NOT considered received unless they have passed our system edits and have been accepted into our system. For every claim filed electronically the provider should receive two reports back:

1. A report that the clearinghouse accepted the claim
2. A file stating the action taken by Blue Advantage (Second Level Acceptance Report)

If you are not receiving both reports, please check with your clearinghouse. It is important to review rejection reports. Working your electronic rejection reports prior to looking up the information via the Blue Advantage Provider Portal for claim status increases the timeliness of the process.

To confirm we are receiving your claims and processing them electronically the sixth position of the claim number that appears on your remittance notice will be an “E.” If the sixth position is a zero, we are receiving paper claims. If your electronic data interchange (EDI) submissions are being rejected and you are not receiving clear direction as to the cause, contact Blue Advantage Customer Service. Explain you are experiencing an ongoing EDI submission issue and you will be directed to the appropriate staff to help work on a resolution.

Please Note: If you fail to identify the correct Blue Advantage payor ID number, the electronic claims file will be returned.

Electronic Claims Submission

All electronic claims must be received via Change Healthcare (professional and facility). Blue Advantage is unable to receive claims filed directly from any other source.
Providers that send directly to Change Healthcare must make the system changes necessary to send their Blue Advantage claims with the Payer ID **84555** to Change Healthcare. For providers that do not send directly to Change Healthcare that wish to send Blue Advantage claims electronically, should notify your clearinghouse as changes to your system will be needed in order for these claims to be submitted electronically to Change Healthcare. Providers must notify our clearinghouse that they would like to file with or their clearinghouse must contact Blue Advantage before their claims will be accepted.

Blue Advantage offers Electronic Remittance Advice availability. Please contact Blue Advantage Customer Service for more information.

**Proper Submission of Provider ID**

Since Blue Advantage is a Medicare Advantage Plan, we follow Medicare billing guidelines. To ensure payments are issued to the correct provider of service we suggest the following claims submission tips:

- All physician services require identification of the rendering provider’s NPI. If you have indicated payment should be issued to a group, this will be done via established processes within our system.

- All extenders, such as nurse practitioners and physician assistants, must be identified since a slightly reduced fee schedule applies under Medicare guidelines.

**Provider ID via Paper Claims**

**CMS-1500 Claim Form:**
Field 25: the tax ID must be indicated

Field 31: the rendering provider’s name must be indicated

Field 24J: the rendering provider’s NPI must be indicated

Field 32: the location where the services were provided

Field 32a: the NPI of the location where the services were provided

Field 33: billing provider name such as the group practice, company name, etc.

Field 33a: billing provider’s NPI

Field 33b: the Blue Advantage legacy ID (see next page)

**UB-04 Claim Form:**
Field 1: provider name, address and telephone number

Field 2: pay to name, address and telephone number

Field 5: the tax ID

Field 56: NPI

Field 57: Blue Advantage legacy ID (see next page)
Blue Advantage does not require your Blue Advantage legacy ID on paper or EDI claims UNLESS you have requested an additional legacy ID to track claims payment separately for different practice locations that carry the same tax ID and NPI number.

As outlined in our EDI reference material, Blue Advantage directly contracts with Change Healthcare. Blue Advantage submits to this clearinghouse a file of all registered providers known as a “Provider Look up File.”

In addition, Blue Advantage provides a “Member Look Up file” to the clearinghouse. The Blue Advantage member ID and member’s first five characters of last name must match in order for the claim to bypass that edit. If you receive individual member rejections, confirm the spelling and spacing in the last name submitted on your file.

**Timely Filing Requirements**

- Both participating and non-participating providers have 12 months from the date of service to file an initial claim
- Both participating and non-participating providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim
  - Resubmit if the whole claim was previously denied or the claim line in question was previously denied
  - Following the corrected claims process, they must submit a corrected claim if all lines of the claim were previously paid and they want to add or remove a claim line or change something on a claim line such as date of service, procedure code, etc.
- **Non-participating providers** have 60 days from the date the claim was processed (remit date) to appeal a claim determination
- **Participating providers** have 12 months from the date the claim was processed (remit date) to dispute a claim determination

Blue Advantage permits claims submission up to 12 months from the date of service. In exchange, Blue Advantage plan policy requires providers resubmit as a new claim any standard billing denials, such as wrong or incomplete member ID, invalid procedure code modifier combination, etc., as a new claim either on paper or electronically, whichever applies to your regular billing method. This is the most expeditious way to receive payment. The resubmitted claim will not be denied as a duplicate claim as long as no payment was issued on the service line in question. If the claim was denied for no prior authorization, please make sure the prior authorization was obtained from Blue Advantage and included on the claim prior to resubmitting the claim.

If a provider is disputing a timely filing denial of a claim, and the claim is filed:

- **Electronically**: The only proof Blue Advantage will accept as timely filing is the second level acceptance report from the clearinghouse that the claim was accepted by Blue Advantage.

- **Paper**: The provider must submit supporting documentation from their practice management system including the applicable field descriptions since the documentation is specific to your system OR a UB-04, CMS-1500 with the original date billed AND documentation must support the claim being submitted within 12 months from the date of service AND follow-up done at a minimum of every 60 days. If there is no documentation supporting the follow-up activity, such as filed second submission MM/DD/YYYY or contacted plan and spoke with ________, on
MM/DD/YYYY, the timely filing denial will stand. We must have the documentation for CMS audits.

Claim Resubmission

A claim is processed by Blue Advantage and provider resubmits the claim generally due to a denial that occurs on either a claim line or the entire claim such as no authorization on file. If an amount was paid on the claim line in question, the provider should not use the claim resubmission process. See additional options below. However, if no payment was issued on the claim line in question the claim can be resubmitted on paper or electronically, not faxed, unless an approved exception is made due to special circumstances. No provider explanation is necessary on the resubmitted claim. The claim will be treated as an initial claim for processing purposes.

Corrected Claims

All corrected claims must be clearly indicated as a correction as follows:

CMS-1500 Claim Form (professional):
- EDI/1500/professional claim forms submitted as “corrected claims” can be submitted electronically.
- In Loop 2300 ~ CLM05-03 must contain a “7,” REF01 must contain an “F8” and REF02 must contain the Original Reference Claim Number.
- 1500 paper claim forms submitted as “corrected claims” can also be submitted on paper. The paper CMS-1500 claim submitted must indicate a Frequency of 7 in Field 22 (Resubmission Code Field) and the Original Reference Claim Number in Field 22 (Original Ref. No. Field).
- The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.

UB-04 Claim Form (facility):
- EDI/UB/facility claim forms submitted as “Corrected Claims” can be submitted electronically.
- The Type of Bill (TOB) must indicate a frequency of 7 and the claim submitted must indicate in Loop 2300 REF01 an “F8” and REF02 must contain the Original Reference Claim Number.
- UB-04 paper claim forms submitted as “corrected claims” can also be submitted on paper.
- The paper UB-04 claim submitted must indicate a frequency of 7 in field 4, the Original Reference Claim Number in field 64 and a reason for the correction in field 80.
Re-openings

Re-openings are generally used by Blue Advantage if the discovery of a clerical error is missed and will proactively reprocess claims based on that finding. For example, we find we have incorrectly denied a certain type of claim for a particular provider and run an extract to identify past denied claims and adjust them in an effort to send out correct payment.

A re-opening may be initiated by a participating provider if the situation does not fall under one of the before mentioned categories, such as Modifier 22 is billed and provider is expecting additional payment. This is not a contract dispute issue and Blue Advantage did not pay additional monies. Providers must submit their request for a re-opening in writing.

If a denial occurred as the result of a Blue Advantage error, the provider is permitted to contact Customer Service and if possible, the necessary action to correct the situation will occur without additional action from the provider.

Provider Pay Disputes

Blue Advantage has made payment on a claim or line but the provider disagrees with the amount that has been paid. The time frame is permitted if brought to our attention within 24 months from when the initial claim was paid. In no case may participating providers seek additional compensation from members other than the applicable member cost share amount.

Provider pay disputes should be submitted in writing. Your request should outline the basis for the dispute and should include documents supporting your position. Please send your written claims dispute requests with all supporting documentation to Blue Advantage Correspondence. The contact information is in the Plan Information Contact List located in the front of this manual.

Blue Advantage will communicate the decision either verbally or in writing if we feel the correct amount was previously paid. If we correct the payment it will appear on a remittance advice to the requesting provider. The review by Blue Advantage and its determination is final.

Disputes other than claims or authorizations should be submitted in writing to Blue Advantage Correspondence.
Formal Dispute Resolution & Arbitration Process

*does not include provider pay disputes*

Dispute Resolution:

Blue Advantage has established a formal dispute resolution process. To initiate the formal dispute resolution process, providers should send a written notice with a brief description of their dispute to:

HMO Louisiana, Inc., Blue Advantage  
Provider Dispute  
P.O. Box 32406  
St. Louis, MO 63132

Within 60 calendar days of our receipt of the provider’s notice, Blue Advantage and the provider will assign appropriate staff members who are to arrange to discuss and seek resolution of the dispute, consistent with the terms of the provider’s agreement with Blue Advantage. Any and all dispute resolution procedures are to be conducted only between Blue Advantage and the provider and shall not include any Blue Advantage member unless such involvement is necessary to the resolution of the dispute. Blue Advantage, in its sole discretion, will determine if the member’s involvement is necessary to the resolution of the dispute.

If Blue Advantage and the provider are unable to reach resolution within the initial 60 day period, then management from both Blue Advantage and the provider, who were not involved in the initial discussion, will have an additional thirty 30 days to resolve the dispute. This time period may be extended by mutual agreement between Blue Advantage and the provider. Blue Advantage and the provider, as mutually agreed, may include a mediator in such discussions. Blue Advantage and the provider shall share the costs of the mediation equally. In any event, if additional meetings are held and no resolution of the dispute is reached within 60 days from the initial meeting, Blue Advantage and the provider shall elect binding arbitration as described in the Arbitration section below in order to resolve the dispute. Blue Advantage or the provider’s failure to participate in the arbitration proceedings means that they have accepted the other’s demands. If resolution of the dispute occurs, Blue Advantage and the provider shall express the resolution in written form or amend the provider’s agreement to include the resolution, if appropriate.

Arbitration:

Both Blue Advantage and the provider shall abide by the following procedures for the arbitration process:

The party (Blue Advantage or the provider) who is initiating the arbitration process shall send written notice to the other party setting forth the basis of the dispute and their desire to arbitrate. Blue Advantage and the provider shall share the costs of the arbitration equally. Arbitration shall be in accordance with the rules and procedures of either the American Arbitration Association or the American Health Lawyers’ Association or another nationally recognized arbitration association acceptable to both Blue Advantage and the provider.

Arbitration shall be conducted in Baton Rouge, Louisiana, before a single arbitrator mutually agreed upon by both Blue Advantage and the provider.

The arbitrator shall be bound by the terms and conditions set forth in the provider’s agreement and the member benefits.
The arbitrator may not award consequential, special, punitive or exemplary damages. The arbitrator may award costs, including reasonable attorney’s fees, against Blue Advantage or the provider. If the decision of the arbitrator does not include such award, both Blue Advantage and the provider shall share the costs of the arbitration equally.

The decision of the arbitrator shall be final and in writing and shall be binding on both Blue Advantage and the provider and enforceable under the laws of the state of Louisiana.

The formal dispute resolution and arbitration processes described above do not supersede or replace the member appeals and grievances process for medical necessity and appropriateness, investigational, experimental or cosmetic coverage determinations as described in the Appeals section of this manual.

**Appeals**

A claim appeal can be filed by either a member or a non-participating provider. Appeals must be filed within 60 days from the date of the initial organizational determination (for example, an EOB is issued or provider remit, whichever is applicable). Appeals must be submitted in writing and do not apply to participating providers unless it involves a pre-service request. Any non-participating provider appeals must include a CMS waiver of liability statement, which states the provider will not bill the member regardless of the outcome of the appeal. The form is sent to the provider upon receipt of any non-participating appeal requests and is also available on our website.

**Member Copayments and Coinsurance**

**Copayment** – It is the provider’s responsibility to collect applicable copayment from members at the time of service.

**Coinsurance** – Blue Advantage members have the responsibility of coinsurance rather than a copayment for some services. If you provide a service to a member that has a member coinsurance, it is your responsibility to bill the member for the coinsurance amount after Blue Advantage makes payment on the claim. The remittance advice will indicate the member’s liability to be billed by your office.

**Maximum Out of Pocket (MOOP)**

MOOP is the maximum a member pays out of pocket for medical (not Part D drugs) covered services within a calendar year.
Balance Billing

The term "balance billing" refers to billing a member above an approved amount for a payable service or billing a member for a service Blue Advantage denied. Please note that Blue Advantage members cannot be “balance billed” in most cases, whether you are a Blue Advantage network provider or not. Blue Advantage members are protected under Medicare balance billing guidelines. The Blue Advantage member is held harmless for payment beyond the Blue Advantage cost share (copayment or coinsurance). The member’s EOB (Your Share) and the provider’s remit notice (Member Responsibility) indicates whether an amount is owed by the member and that is what the provider should follow when billing the member.

If Blue Advantage denies a claim for administrative reasons (invalid procedure code billed, services are not separately payable, timely filing denials, etc.), the claim should be corrected, if applicable, and rebilled for payment consideration. The member should not be billed. Please refer to our claims timely filing policy found elsewhere in this manual.

Advance Beneficiary Notice of Non-coverage (ABN)

ABNs are not applicable to members in Blue Advantage (or any MA plans). Contracted providers must do the following to hold members financially liable for non-covered services not clearly excluded in the member’s EOC (Explanation of Coverage):

- Request a pre-service organization determination from Blue Advantage if they know or have reason to know that a service may not be covered by Medicare.
- If Blue Advantage denies the coverage request, it will issue an Integrated Notice of Denial (IDN) to the member and requesting provider.
- After the member is notified of denial via the IDN, prior to services being rendered, the provider may collect from the member fees for the specific services outlined in the IDN, should the member desire to receive them.

General Billing/Reimbursement Guidelines

Multiple Surgeries

Following are the payment guidelines for a facility for multiple surgical procedures performed at the same operative session:

- **Facilities**
  - Primary Procedure – lesser of charges or 100 percent of fee schedule minus copayments and deductibles, as applicable
  - Secondary Procedure – lesser of charges or 50 percent of fee schedule minus copayments and deductibles, as applicable
  - Third through fifth procedure – lesser of charges or 50 percent of fee schedule minus copayments and deductibles, as applicable
Following are the payment guidelines for physician/practitioner for multiple surgical procedures performed at the same operative session:

**Physician/Practitioner**
- Primary Procedure – lesser of charges or 100 percent of fee schedule minus copayments and deductibles, as applicable
- Secondary Procedure – lesser of charges or 50 percent of fee schedule minus copayments and deductibles, as applicable
- Third through fifth procedure – lesser of charges or 50 percent of fee schedule minus copayments and deductibles, as applicable

Blue Advantage follows Medicare pricing for endoscopy procedures by reducing a multiple, same family, endoscopy claim by the base scope allowable and applying the applicable multiple surgery reductions to different family endoscopy claims.

**Assistant Surgeons**
Following are the payment guidelines for assistant surgeons (assuming that an assistant surgeon is warranted based upon the surgery performed):
- MD – 16 percent of total amount paid to the surgeon minus copayments and deductibles, as applicable;
- PA, nurse practitioner and clinical nurse specialist – reimbursement is limited to 85 percent of the surgeon’s allowable minus any copayments, deductibles, as applicable;
- Multiple surgery restrictions apply.

**TC vs. 26 Pricing (Technical versus Professional)**
Based on standard contract language please be aware of how the allowable is determined for procedures that contain both a technical and professional component, since most contracts limit the additional payment amount such as 115 percent of Medicare’s allowable, to the professional component only. That means if you charge a 71020 (no modifier) so you are billing for a global procedure (both components) and your contracted rate is 115 percent of the Medicare fee schedule the Blue Advantage allowable is determined by 100 percent of the Medicare fee schedule assigned to 71020TC + 115 percent of the Medicare allowable assigned to 7102026.

**Subset Procedure**
Procedural unbundling occurs when two or more procedures are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service. This practice leads to overpayments. When this occurs, the component procedures will be "denied" and re-bundled to pay the comprehensive procedure. If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and re-bundled to the comprehensive code. If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied and the comprehensive code will be added to the claim for payment.
Fraud and Abuse

It is essential for all providers to understand the coding and billing process. Blue Advantage defines fraud, abuse and billing error as follows:

- Fraud is the knowing and willful deception, misrepresentation or reckless disregard of the facts with the intent to receive an unauthorized payment.
- Abuse is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss to the plan. Abuse usually does not involve a willful intent to deceive.
- Billing error is the incorrect submission of services rendered due to factors such as uneducated office staff, coding illiteracy, staff turnover, etc.

If you receive an overpayment, please notify Blue Advantage.

Workers’ Compensation Claims

If you believe that a Blue Advantage patient requires treatment for a work-related illness or injury, ask the patient to contact his or her employer to report that condition in accordance with the State Workers’ Compensation Law. Claims for your treatment of this patient’s work-related illness or injury should be billed to the employer or the employer’s Workers’ Compensation insurer. Blue Advantage’s Certificate of Coverage specifically excludes work-related illnesses and injuries.

If the patient’s employer or the employer’s Workers’ Compensation insurer denies reimbursement for your services, you should advise the patient of that fact. The patient may elect to be treated by a provider who the employer or its insurer designates to treat such work-related conditions or to pay for your services on a fee-for-service basis and then seek reimbursement from the employer or insurer. In any case, it is important to follow Blue Advantage authorization procedures so that if the employee successfully contests the issue, you will be reimbursed.

Coordination of Benefits (COB)

When Blue Advantage is the primary carrier, we will compensate participating providers in accordance with the terms of their Blue Advantage agreements. If the payment does not cover all incurred charges, the provider may submit a claim to a secondary carrier. However, providers may not seek additional compensation for charges from members other than copayments and coinsurance.

When we are the secondary carrier, the provider should first seek payment from the member’s primary carrier. For Blue Advantage to pay the member’s copayment or coinsurance, up to the amount we would have paid had we been the primary carrier, the provider must send us a copy of the explanation of benefits from the primary carrier.

Blue Advantage receives COB information based on CMS records. Claims are adjudicated based on this information. Members are asked to validate the information and notify us immediately if incorrect. Blue Advantage will work with the proper CMS party to have the file updated, but until that is completed, we may continue paying claims as secondary. If you are aware of an issue with the member’s records, do not balance bill the member until the issue is resolved.
Members eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. PHYSICIAN will be informed of Medicare and Medicaid benefits and rules for Members eligible for Medicare and Medicaid. PHYSICIAN may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX of the Social Security Act if the individual were not enrolled in such a plan. PHYSICIAN must (a) accept PLAN’s payment as payment in full, or (b) bill the appropriate state source (42 C.F.R. § 422.504(g)(1)(iii)).

Priority Right of Recovery (Subrogation)

In situations involving settlements to beneficiaries paid by liability insurance, no-fault insurance and uninsured or underinsured motorist insurance that provides payment based on legal liability for injury or illness or damage to property, homeowners’ liability insurance, malpractice insurance, product liability insurance and general casualty insurance Section 1862 (b) of the Social Security Act grants Medicare a priority right of recovery. Section 1862 (b) also gives the Medicare program the right of subrogation for any amounts payable to the program under the Act.

Therefore, Blue Advantage operating a Medicare Advantage contract has the same right of recovery. Blue Advantage’s right to recover its benefits takes precedence over the claims of any other party, including Medicaid.

Claims that contain potential third party liability (TPL) will be paid by Blue Advantage on a conditional basis which permits us to recoup any payments if/when a settlement is reached.

Adjusted Claims, Additional Payments, Overpayments & Voluntary Refunds

Upon discovery of an incorrectly processed claim, Blue Advantage will perform an adjustment. Adjusted claims can be identified on the Provider Remittance Notice as ending in 01, 02, 03, etc. For example claim ID 120060E000000 would be 120060E000001. Facility claims often reflect several “adjustments” due to interim bills.

Blue Advantage claims processing system will compare the adjusted claim payment amount to the prior payment to determine whether the adjustment will result in an additional payment or overpayment. If the claim is adjusted several times, it will not consider the action of all prior adjustments only a single prior one. So a 02 adjustment will not consider what was paid on the 00 only what occurred under the 01 claim. As a result if an 01 adjustment is created in error, causing an overpayment you may be required to issue the refund in order for us to perform an 02 adjustment and issue an additional payment. For your 1099, (tax purposes) our records reflect the correct payment amount on that particular account.

If the adjustment results in additional payment this will appear on the weekly provider remit. Blue Advantage issues additional payments within 30 days of discovery. If the adjustment results in an overpayment, Blue Advantage will issue an overpayment letter, providing all of the previous payment details. Only one notification is sent. In accordance with participating provider’s contractual agreement and non-par CMS regulations, Blue Advantage expects to receive a refund within 30 days of receipt of Blue Advantage notification. To ensure the refund is applied to the proper overpayment, a copy of the overpayment letter should be included with your refund. If no refund is made within 45 days of the date of the overpayment letter, the overpaid amount will be withheld from your next Blue Advantage Provider Remittance Notice. Since this often creates recordkeeping complexities (because the funds are taken from other claim payments/patient accounts) we suggest timely processing of Blue Advantage overpayment requests. If there is insufficient claim activity to recoup the overpayment, via this method, the file will be sent to a collection agency for further collection activity. Once the file is referred for collection, an
additional fee is imposed by the collection agency. Blue Advantage cannot waive this fee. If you disagree with the overpayment in whole or in part, contact Blue Advantage Customer Service immediately to “dispute” the overpayment. During the investigation of the dispute the overpayment will be placed on hold to ensure we do not perform a withhold until the dispute is resolved.

If you discover an overpayment via posting your Blue Advantage payments you are obligated, via your contractual agreement and or CMS regulations, to issue a voluntary refund. Blue Advantage has created a Voluntary Refund Form (see copy in the Forms section of this manual) to ensure all information necessary to process the refund is provided. Your cooperation with timely refunds for overpayments is appreciated.

**Rural Health Clinics Billing Guidelines**

As a Medicare Advantage plan, our Blue Advantage network following the policies and procedures outlined by the CMS. CMS requires a UB-04 claim form for rural health clinic (RHC) services. This differs from Blue Cross’ commercial network billing guidelines for RHC services, which require claims to be submitted on a CMS-1500 claim form. RHC services should be billed on a UB-04 claim form for Blue Advantage members only. For CMS exceptions to this billing guideline, visit the CMS website at [www.cms.gov](http://www.cms.gov), reference MLN Matters Number MM9234 Revised.

**Rules for Coverage that Begins or Ends During an Inpatient Hospital Stay**

On an inpatient hospitalization, if a Blue Advantage member’s coverage terminates during the stay, the entire facility claim will be covered until discharge as long as it was initially authorized. In a skilled nursing facility, the day the member’s coverage terms, is the last day Blue Advantage will cover. For more information on coverage rules for inpatient hospital stays, reference Medicare Managed Care Manual Section 422.318.

**Preadmission Diagnostic Services**

Diagnostic services including, but not limited to, clinical diagnostic laboratory tests, provided by the admitting hospital within three days prior to and including the date of an inpatient admission are not separately payable, but are included in the inpatient payment. The technical component of those diagnostic services performed by a hospital’s wholly owned or wholly operated entities (e.g. physician practices and clinics) are also not separately payable when the Blue Advantage member is admitted as an inpatient within three days.

**Reimbursement When Hospice Has Been Elected**

CMS regulations state the provider of service will bill “Original Medicare” for both hospice and non-hospice related services. Once original Medicare has processed the claim and if a) plan guidelines were followed (in-network providers were used and required prior authorizations were obtained) and b) the member’s cost share under Blue Advantage is less than original Medicare, the services must be submitted to Blue Advantage along with a copy of the remittance notice from original Medicare. Since this will require a paper claims submission, please indicate on the claim “hospice coordination payment request.” This will allow Blue Advantage to reimburse the difference in the member cost share amount, thereby lowering the member’s out-of-pocket expense. This is especially true once the member has met the Blue Advantage Maximum Out-of-Pocket (MOOP) for a given calendar year. Providers may verify both the member’s cost share by benefit category, as well the current MOOP balance, on the Blue Advantage Provider Portal via the Member Eligibility feature.
Example:
Member is hospitalized three days for a total Medicare allowed amount of $25,000. Medicare pays 80 percent of the allowed charge or $20,000 leaving a member cost share balance of $5,000. The hospital is in network with Blue Advantage and prior authorization was obtained. Based on the Blue Advantage plan this member is enrolled in, the member cost share is $325 per day for days 1-6; therefore, a total of $975 is the member’s applicable cost share if the member’s MOOP has not been met.

In the above example, since their Blue Advantage benefit cost share ($975.00) is less than the cost share applied by Original Medicare ($5,000) and plan guidelines were followed Blue Advantage will reimburse the facility the difference of $4,025.

If you are a primary care provider with a capitation arrangement, you will still continue to receive your applicable monthly capitation payment, since you will remain responsible for coordination of care when the member follows plan guidelines. In order to be paid for any 'carve outs' within your contract; you will have to follow the direction noted above (file with Medicare).

Capitation: Reporting Patient Encounters for PCPs

Your agreement with Blue Advantage stipulates that all patient encounters must be reported, regardless of your reimbursement methodology. In addition, state regulatory agencies and CMS require reporting patient encounters. For Blue Advantage members, reporting all patient encounters is a requirement.

Submitting encounter information also benefits the Blue Advantage physician in two ways:

1. Blue Advantage develops its capitation tables based on actual member usage. Having accurate encounter information will assist in establishing tables that are fair and reflect true utilization.
2. Reporting patient encounters relieves the provider of the burden of sorting.

All patient encounters should be submitted to Blue Advantage monthly by ASCII file on disk or on a claim form using the appropriate format outlined in the Claims Submission portion of this manual. Send this information to Blue Advantage Claims.

Failure to submit encounter information may result in our withholding your capitation payment.

Electronic Payment and Remittance

Blue Advantage is capable of sending an Electronic Fund Transfer (EFT) for payment of services and an Electronic Remittance Advice (ERA). To register for EFT, please go to the Blue Advantage Provider Portal, complete the EFT Enrollment Form and follow the directions as outlined.

If you receive the ERA (835), you will not receive an additional paper copy. If you have not signed up for the ERA (835), paper remits are generated and mailed weekly. Paper copies are not available on the Provider Portal.

For enrollment in our ERA/835, please contact the Change Healthcare Customer Service department as Change Healthcare will handle the 835 for Blue Advantage:

Change Healthcare Customer Service:
Phone: 1-877-363-3666
www.emdeon.com

Please note: See the Change Healthcare website for additional features such as the ability to pull down a hard copy remittance notice, which may be available for a fee.
Quality Improvement Services

Purpose of the Quality Management Program

The Quality Management (QM) Program is a coordinated, multidisciplinary approach designed to objectively and systematically monitor and evaluate the quality and appropriateness of care delivery and to identify opportunities to improve care within the organization.

The primary purpose of the QM Program is to promote excellence in care through continuous objective assessment of important aspects of care/service, the resolution of identified problems and the implementation of process improvements. This program will encompass quality management activities that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have beneficial effect on health outcome and patient satisfaction.

Blue Advantage’s QM Committee is an interdisciplinary committee that derives its authority from the governing body and is responsible for the oversight of the QM Program. The mission of the QM Committee is to ensure that members receive quality healthcare and services. The QM Committee meets every other month and may meet more frequently, if deemed necessary.

Quality Committee Structure
**Credentialing**

All contracted and employed physicians and, in some cases, allied healthcare practitioners participating on the physician panel must be credentialed, promoting excellence in medical services delivery. This portion of the QM Program is designed to serve as a guide in the coordination of collecting and reviewing all information that is material to a decision to approve or deny participation status to a practitioner. All contracted physicians, professional practitioners and health delivery organizations must meet minimum credentialing requirements and performance standards. In order to be approved for participation, all practitioners must be in good standing with Medicare and Medicaid.

Independent licensed practitioners who are subject to the credentialing requirements include, but are not limited to, MDs, DOs, DDSs, DMDs, psychiatrists, psychologists, podiatrists, ophthalmologists, optometrists and chiropractors.

Those practitioners who practice exclusively within the inpatient setting will not be subject to the credentialing requirements. Practitioners included in this group are: anesthesiologist, emergency room physicians, pathologists, radiologists and hospitalists.

Provider recredentialing will be completed every three years. Providers failing to complete the recertification process will face termination of their contract with Blue Advantage.

Blue Advantage may delegate credentialing authority to participating networks after their credentialing program has been audited in accordance with applicable State and Federal regulations, applicable accrediting body standards and Blue Advantage’s credentialing guidelines. At least annually, Blue Advantage conducts an audit of the delegated organization’s policies and procedures and the organization’s performance under these standards through review of provider files.

Blue Advantage’s Credentialing Committee includes representation from a range of participating providers. The committee reviews provider credentials and makes recommendations about a provider’s ability to deliver care as a participant in the Blue Advantage provider network. The committee is also responsible for reviewing and making a determination as to the delegation of credentialing authority to participating networks.

**Peer Review**

The Credentialing Committee reports peer review activity to the Quality Management Committee. Peer review activity includes the following:

- monitor and evaluate the quality of medical services rendered by participating providers to Blue Advantage members;
- determine whether a quality of care or service issue exists; and if so, impose Corrective Actions based upon Severity Levels;
- provide educational feedback to providers.
Preventive Health Guidelines

Preventive health guidelines are developed through a review of the medical literature and are reviewed annually or as new information becomes available. It is important to realize that these recommendations are intended to establish an acceptable level of preventive care. Practitioners must use their own judgment in the care of individual patients.

<table>
<thead>
<tr>
<th>Service</th>
<th>Criteria for Screening</th>
<th>Recommendations</th>
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</table>
| Cervical Cancer Screening      | • Sexually active female with an intact cervix              | • Screening should begin within three years from onset of first sexual activity and no later than age 21  
  • Screening should occur every two years  
  • Physician may recommend more frequent intervals if risk factors exist – including abnormal Pap test in last three years or immunodeficiency virus infection  
  • Women over age 65, with previous normal Pap smears may be able to discontinue testing |
| Mammography                   | • All women over age 40  
  • Patients with high-risk family history of breast cancer | • Yearly screening over age 40  
  • Physician may recommend earlier screening if risk factors exist |
| Colon Cancer Screening        | • All patients over age 50                                  | • Occult blood testing annually or  
  • Flexible sigmoidoscopy every four years or once every 10 years after a screening colonoscopy  
  • Colonoscopy every two years if patient is at high risk for colon cancer; and once every 10 years (but not within four years of a screening sigmoidoscopy) if the patient is not at high risk for colon cancer  
  • Double contrast barium enema every two years if at high risk or every four years can be used instead of a sigmoidoscopy or colonoscopy |
| Adult Immunizations           | • Patients are recommended to receive certain vaccinations based on age. Other patients with high risk or infection of diseases being immunized for. | • Annual influenza vaccine for all patients  
  • Pneumococcal vaccine for all immunocompetent or high-risk patients over age 65  
  • Combined tetanus - diphtheria toxoids boosters every 10 years (substitute TDAP for one Td booster if younger than age 65)  
  • Measles and mumps vaccinations to all patients who have not previously been immunized  
  • Hepatitis B - for all young adults not previously immunized and all other patients with high risk for infection  
  • Hepatitis A - for all patients at high risk for infection |
<p>| Prostate Cancer Screening Exams | • All men over age 50 should discuss with their physician | • Annual Digital rectal exam and Prostate Specific Antigen (PSA) tests are examples of screening |</p>
<table>
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<tr>
<th>Service</th>
<th>Criteria for Screening</th>
<th>Recommendations</th>
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</table>
| Cardiovascular Disease Screening             | • All asymptomatic Medicare beneficiaries                                               | • In all asymptomatic Medicare beneficiaries cholesterol and other lipid or triglyceride level blood tests should be drawn once every five years (for example, 59 months after the last covered screening tests)  
• In patients with diabetes or heart disease, cholesterol and other lipid or triglyceride level blood tests should be drawn at least annually |
| Bone Mass Measurements                       | • All females over the age of 60                                                        | • Patients at risk of losing bone mass or at risk of osteoporosis or all women over 60 should be screened at least every two years         |
| "Welcome to Medicare” Physical Exam         | • Initial Screening is a one-time benefit Patients are limited to one routine physical exam every year after the initial screening has been completed | • Annual routine physical exam to include: measurement of height, weight, body mass index and blood pressure; visual acuity screen and education and counseling with respect to covered screening and preventive services  
• The initial “Welcome to Medicare” physical exam can also include an EKG |
| Abdominal Aortic Aneurysm (AAA)              | • Medicare beneficiaries with certain risk factors for AAA                              | • Once in a lifetime  
• Ultrasound screening                                                                 |
| Human Immunodeficiency Virus (HIV) Screening | • Beneficiaries who are at increased risk for HIV infection or pregnant                  | • Annually for beneficiaries at increased risk  
• Three times per pregnancy for beneficiaries who are pregnant:  
  1. When a woman is diagnosed with pregnancy  
  2. During the third trimester and  
  3. At labor, if ordered by the woman’s clinician |
Samples of Forms

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

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<thead>
<tr>
<th>GENERAL INFORMATION</th>
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<tbody>
<tr>
<td>Provider Last Name</td>
<td>First Name</td>
<td>Middle Initial</td>
</tr>
<tr>
<td>Tax ID Number</td>
<td>Provider National Provider Identifier (NPI)</td>
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<tr>
<td>Clinic Name</td>
<td>Clinic National Provider Identifier (NPI)</td>
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<tr>
<td>Languages Spoken</td>
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<td>Address (If Spoken, please specify)</td>
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<tr>
<td>Name of Person Completing Form</td>
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<tr>
<td>Contact Phone Number</td>
<td>Contact Address</td>
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| BILLING ADDRESS CHANGE (for payment remitters, reimbursement checks, etc.) |
|-----------------------------|---|---|
| Former Billing Address      |   |   |
| City, State and ZIP Code    | Phone Number |
| New Billing Address         |   |   |
| City, State and ZIP Code    | Phone Number | Fax Number |
| Email Address               |   | Effective Date of Address Change |

| MEDICAL RECORDS ADDRESS CHANGE (for medical records request) |
|-----------------------------|---|---|
| Former Medical Records Address |   |   |
| City, State and ZIP Code    | Phone Number |
| New Medical Records Address |   |   |
| City, State and ZIP Code    | Phone Number | Fax Number |
| Email Address               |   | Effective Date of Address Change |

Page 1 of 2
**Important:** This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

**Integrated Denial Notice**

**Notice of Denial of Medical Coverage**

**Notice of Denial of Payment**

<table>
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<tr>
<th>Date:</th>
<th>Member Number:</th>
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**Name:**

**Your request was denied.**

We’ve denied, stopped, **reduced** the payment of medical services/items listed below requested by you or your doctor:

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**Why did we deny your request?**

We denied/stopped/reduced the payment of medical services/items listed above because:

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**You have the right to appeal our decision**

You have the right to ask **<<MAO>>** to review our decision by asking us for an appeal:

**Appeal:** Ask **<<MAO>>** for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

**If you want someone else to act for you**

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-866-508-7145 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us.
Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We’ll give you a written decision on a standard appeal within 30 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within 60 days.

Fast Appeal – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 days.

How to ask for an appeal with Blue Advantage

Step 1: You, your representative, or your doctor must ask us for an appeal. Your written request must include:
• Your name
• Address
• Member number
• Reasons for appealing
• Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Mail, fax or deliver your appeal.
For a Standard Appeal: 
For a Fast Appeal: 

What happens next?
If you ask for an appeal and we continue to deny your request for payment of a service, we’ll send you a written decision and automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

Get help & more information
• 1-866-508-7145 Toll Free: TTY users call: 711
• 8:00 AM - 8:00 PM 7 days a week. You may receive a messaging service on weekends and holidays from February 15 through September 30. Please leave a message and your call will be returned the next business day.
• 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
• Medicare Rights Center: 1-888-HMO-9050
• Elder Care Locator: 1-800-677-1116
An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

• Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.

• Be involved in any decisions about your hospital stay, and know who will pay for it.

• Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

  Name of QIO: KEPRO

  Telephone Number of QIO:

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

• You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.

• You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.

  - If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).

• If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.

• Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date/Time

Form CMS-
Steps To Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO: Name of QIO KEPRO

  Telephone Number of QIO:

  - You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is:

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.

- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.

- **Step 4:** The QIO will review your medical records and other important information about your case.

- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  - If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  - If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.

- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Notice Instructions: The Important Message From Medicare

Completing The Notice

A. Header

Hospitals must display “Department of Health & Human Services, Centers for Medicare & Medicaid Services” and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

**Patient Name:** Fill in the patient’s full name.

**Patient ID number:** Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

**Physician:** Fill in the name of the patient’s physician.

B. Body of the Notice

**Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here**

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

**To speak with someone at the hospital about this notice call:** Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

**Patient or Representative Signature:** Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

**Date/Time:** Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

**First sub-bullet – Insert name and telephone number of QIO in bold:** Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

**Second sub-bullet – The name of this hospital is:** Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

**Additional Information:** Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.
<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>Notice of Medicare Non-Coverage for Home Health Care Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State: Zip:</td>
</tr>
<tr>
<td>Phone:</td>
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</table>

**PATIENT INFORMATION**

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<th>Patient Number:</th>
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The Effective Date Coverage of Your Current Home Health Care Services Will End: __________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Home Health Care services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

**Your Right to Appeal This Decision**

- You have the right to an immediate, independent medical review appeal of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

**How to Ask For an Immediate Appeal**

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO 1-855-408-8557 to appeal, or if you have questions.

Blue Advantage is an HMO plan with a Medicare contract. Enrollment in Blue Advantage depends on contract renewal.

See page 2 of this notice for more information.
If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

• If you have Original Medicare: Call the QIO listed on page 1.
• If you belong to a Medicare health plan: Call your plan at the number given below:

Plan contact information: 1-866-508-7145. TTY users should call 711.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____________________________  _______________________
Signature of Patient or Representative  Date
<table>
<thead>
<tr>
<th>Provider Name: ______________________________</th>
<th>Notice of Medicare Non-Coverage for Skilled Nursing Facility Services</th>
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</thead>
<tbody>
<tr>
<td>Address: ____________________________________</td>
<td></td>
</tr>
<tr>
<td>City: __________________ State:____ Zip:________</td>
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<td>Phone: ________________________________________</td>
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**PATIENT INFORMATION**

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The Effective Date Coverage of Your Current Skilled Nursing Facility Services Will End: ____________________________

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Facility services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

**Your Right to Appeal This Decision**

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer will also look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above:
  - Neither Medicare nor your plan will pay for these services after that date.
  - If you stop services no later than the effective date indicated above, you will avoid financial liability.

**How to Ask For an Immediate Appeal**

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO 1-855-408-8557 to appeal, or if you have questions.

Blue Advantage is an HMO plan with a Medicare contract. Enrollment in Blue Advantage depends on contract renewal.

*See page 2 of this notice for more information.*
If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: 1-866-508-7145. TTY users should call 7-1-1.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

______________________________  ________________
Signature of Patient or Representative  Date

Form CMS 10123-NOMNC (Approved XX/XX/2015)
The purpose of this form is to provide Blue Advantage (HMO) with sufficient identifying information to ensure your voluntary refund is processed accurately.

Please complete all applicable areas below:

**Facility/Provider/Physician/Supplier Information**
- Facility/Provider/Physician/Supplier Name
- Street Address, City, State, Zip
- Blue Advantage Provider ID Number/NPI (This is located on your remittance notice)

**Contact Person**
- Phone No.

**Check Amount**
- $ Check

**Refund Information**
- Please provide this information for each refund if multiple patients are involved.

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Member ID</th>
<th>Claim Number (This is located on your remittance notice)</th>
<th>Date of Service</th>
<th>Service Code</th>
<th>Modifier</th>
<th>Refund Amount</th>
</tr>
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<tbody>
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</tbody>
</table>

**Reason for Refund**
- [ ] Corrected Bill
- [ ] Not our Patient
- [ ] Service Rejected
- [ ] Patient Not Effective
- [ ] Other Insurance
- [ ] Billed in Error
- [ ] Duplicate
- [ ] Other (please specify)

**For Use By Internal Staff Only**
- Date Processed
- Processor's Initials
- Logged in Receipts
- Claims Correction Performed

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

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Blue Advantage from HMO Louisiana, Inc. is an HMO plan with a Medicare contract. Enrollment in HMO Louisiana depends on contract renewal. HMO Louisiana is a subsidiary of Blue Cross and Blue Shield of Louisiana, Independent licensees of the Blue Cross and Blue Shield Association.