Blue Medicare Advantage (PPO)

A Supplement to the BlueChoice® Facility Manual

07/11/2016
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Blue Medicare Advantage (PPO): Overview and Introduction

Our Name

Blue Medicare Advantage (PPO)SM is a product of HCSC Insurance Services Company (HISC), a wholly owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Introduction

Blue Medicare Advantage (PPO) is pleased to welcome you as a Participating Facility. The BlueChoice Facility Manual plus this Supplement explain the policies and procedures of the Blue Medicare Advantage (PPO) network. We hope it provides you and your staff with helpful information as you serve Blue Medicare Advantage (PPO) Members. The information is intended to provide guidance in most situations your Facility will encounter while participating in the Blue Medicare Advantage (PPO).

This supplement to the Blue Choice Facility Manual is applicable only to the operation of Blue Medicare Advantage (PPO).

The Blue Medicare Advantage (PPO) Network

Blue Medicare Advantage (PPO) is a Medicare Advantage Plan. Blue Medicare Advantage (PPO) maintains and monitors a network of Participating Providers including physicians, hospitals, skilled nursing facilities, ancillary providers and other health care providers through which Members obtain Covered Services.

Blue Medicare Advantage (PPO) will market its Medicare Advantage Plan to individuals eligible for Medicare Parts A and B that live in its approved Service Area in the state of Texas. Blue Medicare Advantage (PPO) will furnish Members with a Member Handbook and Evidence of Coverage that will include a summary of the terms and conditions of its plan.

Blue Medicare Advantage (PPO) Claims & Customer Service

The following list the name, address and phone numbers for the Blue Medicare Advantage (PPO) Claims and Customer Service Office:

Blue Medicare Advantage (PPO)
P.O. Box 660044
Richardson, TX  75266-0044

Provider Customer Service: 877-774-8592

Hours:  8:00 am to 8:00 pm local time, 7 days a week. From 2/15 through 9/30 alternate technologies will be used on weekends and holidays.
Facility providers should submit claims electronically for all services provided to Blue Medicare Advantage (PPO) Members (Payor ID 84980).

Hospitals should also submit claims to its Medicare fiscal intermediary for all services that it provides to Blue Medicare Advantage (PPO) Members during the term of this Amendment so that the Intermediary can calculate any Medicare payments due to the Facility for the exclusions.

Claims should be submitted within 180 days from date of service or the date of discharge on inpatient claims using the standard CMS-1500 or UB04 Claim Form or electronically as discussed below. Claims submitted after the 180 days from the date of service/discharge date are not eligible for reimbursement. Blue Medicare Advantage (PPO) providers/facilities may not seek reimbursement from the member for claims submitted after the 180 day deadline.

Hospitals must bill on UB04 claim form or Facility electronic claim format ANSI 837I version– 4010A1 or the T60 format.

Ancillary providers that bill on a CMS 1500 claim form or Professional electronic claim format ANSI837P version- 4010A1 or the T0301 format.

Electronic billing:
- Claims should be submitted to Blue Medicare Advantage (PPO)
- Blue Medicare Advantage (PPO) Electronic Payor ID – 84980
- For information on electronic filing contact Availity at 1-800-282-4548.

Blue Medicare Advantage (PPO) claims containing the adequate information and submitted in accordance with these guidelines will be paid within 45 days for paper claims and 30 days for electronic claims. Please include the member’s complete ID number exactly as shown on the card including the 3 letter alpha prefix of ZGD.

Duplicate claims may not be submitted prior to the applicable 30 day for electronic or 45 days for paper claims.

**NOTE:** If submitting a paper claim, mail to Blue Medicare Advantage (PPO) at: P.O, Box 660044 Dallas Texas 75266-0044.

**IMPORTANT:** Always refer to your Facility Contract for information on claims submission, reimbursement and additional detailed information. Information on the Availity (electronic submission) can be located on the Availity.com website.
## Program Overview, continued

### Hospital Services

All inpatient admissions require prior authorization from the Blue Medicare Advantage (PPO) Utilization Management (UM) Department. The prior authorization process for admissions is carried out by the admitting physician or hospital personnel.

Admitting physicians are responsible for contacting the UM Department to request authorization for additional days if an extension of the approved length of stay is required. The admitting physician will provide appropriate referrals for extended care. Blue Medicare Advantage (PPO) UM personnel will assist with coordinating all services identified as necessary in the discharge planning process.

### Coordination of Benefits

If a Member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by Blue Medicare Advantage (PPO) will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.

### Claim Disputes

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the Blue Medicare Advantage (PPO) Provider Customer Service Department at 877-774-8592.

### Balance Billing

You **may not** bill a Member for a non-covered service unless:

1. You have informed the Member in advance that the service is not covered, and,
2. The Member has agreed in writing to pay for the services if they are not covered. ABN? - Advanced Beneficiary Notice

### Process used to Recover Overpayments on Claims

If an overpayment occurs on a Blue Medicare Advantage (PPO) Facility Provider's claim, the process that will be used to recover an overpayment will be auto-recoupment. Should you have any questions, please contact Blue Medicare Advantage (PPO) Provider Customer Service.
Medical Records

Network providers are required to provide medical records requested by Blue Medicare Advantage. The medical records are used for CMS audits of risk adjustment data which are used to determine health status adjustments to CMS capitation payments to the Medicare Advantage organization. Medical records are also used for the following:

- Advance determination of coverage
- Plan coverage
- Medical necessity
- Proper billing
- Quality reporting,
- Fraud and abuse investigations
- Plan Initiated internal risk adjustment validation

Behavioral Health Services

Members requiring Behavioral Health Services (Mental Health and Chemical Dependency) are required to call at 877-774-8592 Care Delivery. Telephonic access is available 24 hours a day, 7 days a week.

Customer Service Representatives and Care Managers provide:

- Preauthorization for inpatient and outpatient care
- Referral services, if required
- Case management
- Assistance in the selection of a Participating Facility Provider
- Crisis interventions

The following referral procedures apply to behavioral health services only:

- All behavioral health services must be preauthorized by BCBSTX. **NOTE:** Whether the services are Medically Necessary must be determined before an authorization number will be issued. **Claims received that do not have a preauthorization number will be denied.** Blue Medicare Advantage (PPO) Facilities may not seek payment from the Member when a claim is denied for lack of a preauthorization number.
- The call to preauthorize can be made by the member or the member’s physician.

Participating Physicians/Professional Providers are encouraged to admit patients to a participating facility unless an emergency situation exists that precludes safe access to a network facility or if the admission is approved for a non-participating facility.

**NOTE:** To obtain benefits and eligibility as well as claims processing questions or status call Blue Medicare Advantage (PPO) Provider Customer Service at: 877-774-8592
General Information

ID Cards & Verification of Coverage

Each Blue Medicare Advantage (PPO) Member will receive a Blue Medicare Advantage (PPO) identification (ID) card containing the Member's name, Member number, and information about their benefits.

At each visit, your staff should:

- Ask for the Member’s ID card and have a copy of both sides in the Member’s records.

- Determine if the Member is covered by another health plan to record information for coordination of benefits purposes.

- Refer to the Member’s ID card for the appropriate telephone number to verify eligibility in the Blue Medicare Advantage (PPO), deductibles, coinsurance amounts, co-payments, and other benefit information.

Sample of ID Card

![Sample of ID Card](image)
**General Information, continued**

**Emergency Services**

Covered inpatient or outpatient services that are:
- furnished by a provider qualified to furnish Emergency Services; and
- needed to evaluate or stabilize an Emergency Medical Condition.

**Emergency Medical Conditions**

Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:
- Serious jeopardy of the patient’s health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Medicare product does not cover pregnancy benefit. Not applicable to this product.

**Emergency Care**

Emergency Care services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:
- Serious jeopardy of the patient’s health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Emergency Care services necessary to evaluate and stabilize an Emergency Medical Condition are covered by Blue Medicare Advantage. Members with an Emergency Medical Condition should be instructed to go to the nearest Emergency Provider. Evaluation and stabilization of an Emergency Medical Condition in a hospital or comparable facility does not require precertification. Emergency Care services will be covered at the in-network benefit level.

**Out-of-Area Renal Dialysis Services**

A member may obtain Medically Necessary dialysis services from any qualified physician or other professional provider the member selects when he/she is temporarily absent from the Blue Medicare Advantage Service Area and cannot reasonably access Blue Medicare Advantage dialysis physicians and other professional providers. No precertification or notification is required. However, a member may voluntarily advise Blue Medicare Advantage if he/she will temporarily be out of the Service Area. Blue Medicare Advantage may assist the member in locating a qualified dialysis physician or other professional provider.
Clinical Pathology Laboratories (CPL) is the participating outpatient clinical reference laboratory services for Blue Medicare Advantage.

To schedule an appointment, log onto http://www.cpllabs.com/ or call 800-595-1275.

To locate other participating labs in Blue Medicare Advantage, visit the Online Provider Directory (Provider Finder) through the BCBSTX website at bcbstx.com/provider.

If lab services are performed at the participating physician’s or other professional provider’s office, the physician or professional provider may bill for the lab services. However, if the physician’s or other professional provider’s office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Medicare Advantage for the lab services.

Note: Effective January 2009, claims with lab services will be denied if the CLIA number is not on the CMS-1500 form in field 23.

Reminder of CLIA Requirements

This is a reminder that Blue Medicare Advantage follows the same billing and coverage guidelines as Original Medicare. This includes the requirement to report the Clinical Laboratory Improvements Amendments of 1988 (CLIA) number on claims submitted by all laboratories, including physician office laboratories. The CLIA number must be included on each Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. The CLIA number is required in field 23 of the paper Form CMS-1500. Modifier QW must be reported on claims for CLIA waived laboratory tests. The CLIA number is not required on the Form CMS-1450 (UB04).

What is BCBS Medicare Advantage (MA) PPO Network Sharing?
All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

What does the BCBS MA PPO Network Sharing mean to me?
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas and you provide services for any BCBS MA PPO
BlueCard and Blue Medicare Advantage (PPO) continued

members, you will receive the Medicare allowed amount for covered services. For Urgent or Emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

The “MA” in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.

Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?

If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX), you should provide the same access to care as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BCBS MA PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?

Call BlueCard Eligibility at 800-676-BLUE (2583) and provide the BCBS MA PPO member’s alpha prefix located on the member’s ID card.

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:

- Log in to Availity, or RealMed or your preferred vendor
- Enter required data elements
- Submit your request
Blue Card and Blue Medicare Advantage (PPO) continue

Where do I submit the claim?
You should submit the claim to Blue Cross and Blue Shield of Texas (BCBSTX) under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?
If you are a BCBS MA PPO contracted provider with Blue Cross and Blue Shield of Texas, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO Network Sharing?
When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, Blue Cross and Blue Shield of Texas will send you the payment. However, these services will be paid under the BCBS MA member’s out-of-network benefits unless for urgent or emergency care.

What is the BCBS MA PPO member cost sharing level and copayments?
A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member’s health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800-676-BLUE (2583).

May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?
No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or copays.

What if I disagree with the reimbursement amount I received?
If there is a question concerning the reimbursement amount, contact Blue Medicare Advantage (PPO) Provider Customer Service at 877-774-8592.

Who do I contact if I have a question about BCBS MA PPO network sharing?
If you have any questions regarding the BCBS MA PPO program or products, contact Blue Medicare Advantage (PPO) Provider Customer Service at 877-774-8592.
CARE MANAGEMENT, QUALITY IMPROVEMENT AND UTILIZATION REVIEW PROGRAMS

The Utilization Management program does not prohibit providers from advocating on behalf of Members within the utilization management process.

<table>
<thead>
<tr>
<th>Utilization Management Program</th>
<th>iExchange Access</th>
<th><a href="http://www.bcbstx.com/provider">www.bcbstx.com/provider</a> or 877-774-8592</th>
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<tr>
<td>Utilization Management Department Contact Numbers</td>
<td>877-774-8592</td>
<td>(If iExchange system is unavailable)</td>
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<tr>
<td></td>
<td>855-390-6567</td>
<td>Case Management Fax</td>
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<tr>
<td></td>
<td>855-610-9835</td>
<td>Behavioral Health Fax</td>
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<td>Note: Refer to the On-Line BlueChoice® Facility Manual for additional information.</td>
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The admitting physician, other professional provider or hospital or other inpatient facility should notify the UM Department if they are admitting a Blue Medicare Advantage member to a hospital or other inpatient facility.

The admitting physician, other professional provider or hospital/facility should utilize the iExchange Web application at bcbstx.com/provider or the iExchange Interactive Voice Response (IVR) phone system at 877-774-8592 and provide the following information:

- Name of admitting physician or other professional provider
- Member’s name, sex, date of birth and Blue Medicare Advantage ID number
- Admitting facility/hospital
- Primary diagnosis
- Reason for admission
- Date of admission
- Requested length of stay

The UM Department will review the initial hospitalization request to confirm that the hospitalization and/or procedures are Medically Necessary. If the UM Department concludes that certain services are not Medically Necessary, the physician reviewer will attempt to contact the admitting physician or other professional provider to discuss the treatment plan and treatment options prior to issuing the denial determination.
CARE MANAGEMENT, QUALITY IMPROVEMENT AND UTILIZATION REVIEW PROGRAMS, continued

If an extension of the initially approved length of stay is required, the admitting physician and other professional provider or Hospital/Facility should contact the UM Department to request the extension.

UM Department clinical staff will assist participating physicians and other professional providers and facilities/hospitals in the inpatient discharge planning process. At the time of admission and during the hospitalization, the UM Department clinical staff will discuss discharge planning with the participating physician and professional provider, member and member’s family.

For routine radiology services refer to the BlueChoice Facility Provider – Provider Manual – Section B.
Pre-Approval Requirements

The attending physician must obtain preauthorization for the services listed below except in an emergency.

### Medical/Surgical

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<tr>
<td>Acute Inpatient Hospital</td>
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<tr>
<td>Ambulance (A0430, A0431, A0435, A0436)</td>
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<tr>
<td>Chemical Denervation Eccrine Glands (64650-64653)</td>
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<tr>
<td>DME greater than $2500</td>
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<tr>
<td>Home Health Agency Care</td>
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<tr>
<td>Inpatient Rehabilitation</td>
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<tr>
<td>Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>Medications (J0585, J0881, J0882, J0885, J0897, J1745, J3262, J9035, J9310)</td>
</tr>
<tr>
<td>Organ Transplants other than ocular and kidney</td>
</tr>
<tr>
<td>Plastic, Reconstructive and Aesthetic Surgery (15775-15835)</td>
</tr>
<tr>
<td>Prosthetics/Orthotics greater than $2500</td>
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<tr>
<td>Skilled Nursing Facility (SNF)</td>
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</table>

### Behavioral Health

<table>
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<tr>
<th>Service Description</th>
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<tbody>
<tr>
<td>All Inpatient Stays</td>
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<td>Partial Hospitalization Program (PHP)</td>
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### Out of Plan / Out of Network Referrals

A referral to an out-of-plan or out-of-network provider which is necessary due to network inadequacy or continuity of care must be reviewed by the BCBSTX Utilization Management prior to a BCBSTX patient receiving care.

The Blue Cross Medicare Advantage PPO referring physician or professional provider must contact the Utilization Management Department at the number listed below to request an out-of-plan or out-of-network referral authorization. For requests that are approved, the Utilization Management Department will forward an approval letter to the out-of-plan or out-of-network physician or professional provider.

Requests for out-of-plan or out-of-network referrals should be directed to:

**BCBSTX Utilization Management Department (For Medical and Behavioral Health Services)**

**(call) 877-774-8592 or (fax) 855-874-4711**

Hours: 6 am – 6 pm (CT), M-F and non-legal holidays and 9 am to 12 noon (CT), Saturday, Sunday and legal holidays. Messages may be left in a confidential voice mailbox after business hours.

If the out-of-network/plan provider determines that additional care is needed, the provider must obtain additional approval from the Utilization Management Department.

**Note:** Whether the services are Medically Necessary must be determined before a precertification number will be issued. Claims received that do not have a precertification number will be denied. Blue Medicare Advantage physicians and other professional providers may not seek payment from the member when a claim is denied for lack of a preauthorization.
Medical Necessity

Blue Medicare Advantage determinations must be based on:

1. The medical necessity of plan-covered services – including emergency, urgent care and post-stabilization-based – based on internal policies (including coverage criteria no more restrictive than original Medicare’s national and local coverage policies) reviewed and approved by the medical director;
2. Where appropriate, involvement of the Blue Medicare Advantage medical director; and
3. The member’s medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage late on the base of a lack of medical necessity.

If the Medicare Advantage organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical or other expertise, including knowledge of Medicare coverage criteria, before the Medicare Advantage organization issues the organization decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

Medical Policy

Physicians and other professional providers participating in the Blue Medicare Advantage network should refer directly to Medicare coverage policies when making coverage decisions. There are two types of Medicare coverage policies. National Coverage Determinations and Local Coverage Determinations described below. As a Medicare Advantage plan, Blue Medicare Advantage must cover all services and benefits covered by Medicare. Coverage information that you receive concerning original Medicare also applies to Blue Medicare Advantage.
National Coverage Determinations (NCDs)
The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are found at http://cms.hhs.gov/manuals/. Key manuals for coverage include:
  - Medicare National Coverage Determination Manual
  - Medicare Program Integrity Manual
  - Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network. These articles can be found at www.cms.hhs.gov/MLNMattersArticles/.

Local Coverage Determinations (LCDs)
CMS contractors (e.g., carriers and fiscal intermediaries) develop and issue local coverage determination (LCDs) to provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

Provider may access our region’s LCDs at the following website addresses:
  - Durable Medical Equipment (DMERC): www.cgsmedicare.com
  - Medicare Part B: www.trailblazer.com
  - Medicare Part A: www.trailblazer.com
  - Regional Home Health Intermediary (RHHI): www.palmettogba.com

Medicare Coverage Database

The following areas may be searched:
  - National Coverage Determinations (NCDs)
  - National Coverage Analyses (NCAs) – These documents support the NCD process.

Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is updated on a monthly basis. Therefore, the most current information should be accessed through the local websites listed in the area above.

In coverage situations where there is an NCD, LCD, or guidance on coverage in original Medicare manuals, an Medicare Advantage organization may adopt the coverage of other Medicare Advantage organizations in its service area. The Medicare Advantage organization may also make its own coverage determination and provide a rationale using an objective evidence based process.
Performance and Compliance Standards – Utilization Management, continued

Utilization Management Appeals Address

Appeals regarding authorization for, or termination of coverage of, a healthcare service should be sent to:

Blue Medicare Advantage (PPO)
Attn: Appeals and Grievances
P.O. Box 4288
Scranton, PA 18505
Fax Number: 855-674-9185
## Benefits-Beneficiary Rights

### Non Discrimination

A Blue Medicare Advantage plan may not deny, limit or condition enrollment to individuals eligible to enroll in a Medicare Advantage plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following: claims experience; receipt of health care; medical history and medical conditions arising out of acts of domestic violence; evidence of insurability including conditions arising out of acts of domestic violence and disability. Additionally, an Medicare Advantage organization must:


Ensure that its Medicare Advantage plans have procedures in place to ensure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

### Confidentiality

The Medicare Advantage organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify purposes for which the information will be used within the organization and to whom and for what purpose it will disclose information outside the organization.

### Basic Rule

A Medicare Advantage organization offering a Medicare Advantage plan must provide the following to plan enrollees:

- All Part A and Part B, original Medicare services, if the enrollee is entitled to benefits under both parts.

- Part B services if the enrollee is a grandfathered “Part B only” enrollee.

The Medicare Advantage organization fulfills its obligation of providing Original Medicare benefits by furnishing the benefits directly through arrangements, or by paying on behalf of enrollees for the benefits. The following requirements apply with respect to the rule that Medicare Advantage organizations must cover the costs of Original Medicare benefits:

- **Benefits** – Medicare Advantage plans must provide or pay for medical necessary Part A (for those entitled) and Part B covered items and services.

- **Access** – Medicare Advantage enrollees must have access to all medically necessary Parts A and B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under Original Medicare.
Benefits-Beneficiary Rights, continued

**Basic Rule, continued**

- **Cost-Sharing** – Medicare Advantage plans may impose cost-sharing for a particular item or service that is above or below Original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under Original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries.

The following circumstances are exceptions to the rule that Medicare Advantage organizations must cover the costs of Original Medicare benefits:

- **Hospice** – Original Medicare (rather than the Medicare Advantage organization) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan.

- **Inpatient stay during which enrollment ends** – Medicare Advantage organizations must continue to cover inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of an inpatient stay.

- **Clinical Trials** – Original Medicare pays for the costs of routine services provided to a Medicare Advantage enrollee who joins a qualifying clinical trial. Medicare Advantage plans pay the enrollee the difference between Original Medicare cost-sharing incurred for qualifying clinical trial items and services and the Medicare Advantage plan’s in-network cost-sharing for the same category of items and services.

In addition to providing Original Medicare benefits, to the extent applicable, the Medicare Advantage organization also furnishes, arranges, or pays for supplemental benefits and prescription drug benefits to the extent they are covered under the plan.

**Uniform Benefits**

All plan benefits must be offered uniformly to all enrollees residing in the service area of the plan and must be offered at uniform premium, with uniform benefits and cost-sharing throughout the plan’s service area.
**Benefits-Beneficiary Rights, continued**

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent an 1135 waiver by the Secretary, Medicare Advantage plans are expected to:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities
- Waive in full, requirements for gatekeeper referrals where applicable;
- Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and

Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.

**Access and Availability Rules**

An Medicare Advantage organization may specify the providers through whom enrollees may obtain services if it ensures that all Original Medicare covered services and supplemental benefits contracted for, by, or on behalf of Medicare enrollees are available and accessible under the coordinated care requirements. To accomplish this, the organization must meet the following requirements:

- Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care.

Establish and maintain provider network standards that define the types of providers to be used when more than one type of provider can furnish a particular item or service; identify the types of mental health and substance abuse providers in their network; and specify the types of providers who may serve as a member’s primary care physician.

- Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care.
Benefits-Beneficiary Rights, continued

Establish and maintain provider network standards that define the types of providers to be used when more than one type of provider can furnish a particular item or service; identify the types of mental health and substance abuse providers in their network; and specify the types of providers who may serve as a member’s primary care physician.

- Employ written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS. These standards must ensure that the hours of operation of the Medicare Advantage organization’s providers are convenient to, and do not discriminate against, members. The Medicare Advantage organization must also ensure that, when medically necessary, services are available 24 hours a day, 7 days a week. This includes requiring primary care physicians to have appropriate backup for absences. The standards should consider the member’s need and common waiting times for comparable services in the community.

(Examples of reasonable standards for primary care services are:

1) *urgently needed services or emergency - immediately*;
2) services that are not emergency or urgently needed, but in need of medical attention - within one week; and
3) routine and preventive care - within 30 days.)

- Establish, maintain, monitor and validate credentials for a panel of primary care providers from which the member may select a personal primary care provider

- Provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services. The Medicare Advantage organization must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member’s medical needs.

- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how an Medicare Advantage organization may meet these accessibility requirements include but are not limited to provision of translator services, interpreter services, teletypewriters or TTY (text telephone or teletypewriter phone) connections.
Benefits-Beneficiary Rights, continued

- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management protocols that allow for individual medical necessity determinations. These standards must be available to both enrollees and providers.
- Provide coverage for ambulance services, emergency and urgently-needed services, and post-stabilization care services. Ambulance services include services dispatched through 911 or its local equivalent, when either an emergency situation exists or other means of transportation would endanger the beneficiary's health.

Cost-Sharing for In Network Preventive Services

Medicare Advantage organizations are required to cover without cost-sharing all in-network Medicare covered preventive services for which there is no cost-sharing under Original Medicare.

Medicare Advantage organizations may not charge for facility fees, professional services, or physician office visits if the only service(s) provided during the visit is a preventive service that is covered at zero cost-sharing under Original Medicare. However, if during provision of the preventive service, additional non-preventive services are furnished, then the plan’s cost-sharing standards apply.

Enrollees of an Medicare Advantage organization may directly access (through self-referral to any plan participating provider) in-network screening mammography and influenza vaccine. The Medicare Coverage webpage is at: http://www.cms.gov/center/coverage.asp.

Drugs Covered Under Original Medicare Part B

The following broad categories of drugs may be covered under Medicare Part B, subject to coverage requirements and regulatory and statutory limitations:

- Injectable drugs that have been determined by Medicare Contract Administrative Contractors (MAC) to be "not usually self-administered" and are administered incident to physician services
- Drugs that the MA enrollee takes through durable medical equipment (i.e., Nebulizers)
- Certain vaccines including pneumococcal, hepatitis B (high or intermediate risk), influenza, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition.
Benefits-Beneficiary Rights, continued

Drugs Covered Under Original Medicare Part B, continued

- Certain oral anti-cancer drugs and anti-nausea drugs
- Hemophilia clotting factors
- Immunosuppressive drugs
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of end stage renal disease
- Some drugs are covered under either Part B or Part D depending on the circumstances. For clarification on coverage under Part B versus Part D, refer to Appendix C, Chapter 6 of the Prescription Drug Manual:

Medical Supplies Associated with the Delivery of Insulin

Medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies, and needle-free syringes, can satisfy the definition of a Part D drug. However, test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D.

Clinical Trials

For clinical trials covered under the Clinical Trials National Coverage Determination (NCD), Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials. The Clinical Trial National Coverage Determination defines what routine costs means and also clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Refer to the Medicare Clinical Trial Policies page at http://www.cms.gov/ClinicalTrialPolicies/ for more information.

Medicare Advantage plans pay the enrollee the difference between Original Medicare.

Advance Directives

The Medicare Advantage organization must provide to its adult enrollees, at the time of initial enrollment, written information on their rights under the law of the state in which the Medicare Advantage organization furnishes services to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.
Facility Performance Standards and Compliance Obligations

Marketing

Participating Facilities may not develop and use any materials that market Blue Medicare Advantage (PPO) without the prior approval of Blue Medicare Advantage (PPO) in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are approved prior to use by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions under Federal Health Programs and State Law

Participating Facilities must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the Participating Facility.

Participating Facilities must disclose to Blue Medicare Advantage (PPO) whether the Participating Facility or any staff Member or subcontractor has any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of Texas; the federal government; or any public insurer. Participating Facilities must notify Blue Medicare Advantage (PPO) immediately if any such sanction is imposed on Participating Facility, a staff Member or subcontractor.
### Medical Records

**Medical Record Review**
A Blue Medicare Advantage (PPO) representative may visit the Participating Facility to review the medical records of Blue Medicare Advantage (PPO) Members. Discuss with Share re: requirements.

**Standards for Medical Records**
Participating Facilities must have a system in place for maintaining medical records that conform to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the Members’ medical records.

**Advance Directive**
Participating Facilities must document in a prominent part of the Member’s current medical record whether or not the Member has executed an Advance Directive.

Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the state of Texas and signed by a patient, that explain the patient’s wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

**Confidentiality of Member**
Participating Facilities must comply with all state and Federal laws concerning confidentiality of health and other information about Members. Participating Facilities must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.
Reporting Obligations

Blue Medicare Advantage (PPO) must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective Members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates; information on Member satisfaction; and information on health outcomes. Participating Facilities must cooperate with Blue Medicare Advantage (PPO) in its data reporting obligations by providing to Blue Medicare Advantage (PPO) any information that it needs to meet its obligations.

Certification of Diagnostic Data

Blue Medicare Advantage (PPO) is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a Member and a facility, supplier, physician, or other practitioner (encounter data). Participating Facilities that furnish diagnostic data to assist Blue Medicare Advantage (PPO) in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.
Initial Decisions

The “initial decision” (adverse determination) is the first decision Blue Medicare Advantage (PPO) makes regarding coverage or payment for care. In some instances, a Participating Facility, acting on behalf of a Blue Medicare Advantage (PPO) Member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a Member asks Blue Medicare Advantage (PPO) to pay for medical care the Member has already received, this is a request for an “initial decision” about payment for care.

- If a Member, or Participating Facility acting on behalf of a Member, asks for preauthorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by Blue Medicare Advantage (PPO).

- If a Member asks for a specific type of medical treatment from a Participating Facility, this is a request for an “initial decision” about whether the treatment the Member wants is covered by Blue Medicare Advantage (PPO).

Blue Medicare Advantage (PPO) will generally make decisions regarding payment for care that Members have already received within 30 days.

A decision about whether Blue Medicare Advantage (PPO) will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 days) or it can be an expedited decision that is made more quickly (typically within 72 hours).

A Member can ask for an expedited decision only if the Member or any physician/professional provider believes that waiting for a standard decision could jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function. The Member or a physician/provider can request an expedited decision. If an expedited decision is requested by the member or physician/provider, Blue Medicare Advantage (PPO) will automatically provide an expedited decision.

If Blue Medicare Advantage (PPO) does not make a decision within the timeframe and does not notify the Member regarding why the timeframe must be extended, the Member can treat the failure to respond as a denial and may appeal, as set forth below.
**Appeals and Grievances**

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. Appeals and Grievances are the two different types of complaints they can make. All Participating Facilities must cooperate in the Blue Medicare Advantage HMO/PPO Appeals and Grievances process.

- An appeal is the type of complaint a Member makes when the Member wants Blue Medicare Advantage HMO/PPO to reconsider and change an initial decision (by Blue Medicare Advantage HMO/PPO or a Participating Facility) about what services are necessary or covered or what Blue Medicare Advantage HMO/PPO will pay for a service.
- A grievance is the type of complaint a Member makes regarding any other type of problem with Blue Medicare Advantage HMO/ PPO or a Participating Facility. For example, complaints concerning quality of care, waiting times in the waiting room, and the cleanliness of the facilities are grievances. Facility agrees to address concerns of member’s with their Facility Provider Network Representative.

**Appeals and Grievances Address**

Appeals regarding authorization for, or termination of coverage of, a health care service should be mailed or faxed as follows:

Blue Medicare Advantage (PPO)
Attn: Appeals and Grievances
P.O. Box 4288
Scranton, PA 18505
Appeals Fax Number: 855-674-9185
Grievances Fax Number 855-674-9189

NOTE: For claims submission errors contact Blue Medicare Advantage (PPO) Provider Customer Service at 1-877-774-8592.

**Resolving Grievances**

If a Blue Medicare Advantage (PPO) Member has a grievance about Blue Medicare Advantage (PPO), a Facility or any other issue, Participating Facilities should instruct the Member to contact Blue Medicare Advantage (PPO) Customer Service Department at the number listed on the back of the Member’s ID card.
Resolving Appeals

A Member may appeal an initial adverse determination by Blue Medicare Advantage (PPO) or a Participating Provider concerning precertification for, or termination of coverage of, a health care service. A Member may also appeal an adverse initial decision by Blue Medicare Advantage (PPO) concerning payment for a health care service. A Member’s appeal of an initial decision about authorizing health care or terminating coverage of a service must generally be resolved by Blue Medicare Advantage (PPO) within 30 calendar days or sooner if the Member’s health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

If the normal time period for an appeal could jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function, the Member or the Member’s physician can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the Member’s interest to extend this time period. When a member or physician requests an expedited appeal, Blue Medicare Advantage (PPO) will automatically expedite the appeal.

Hospital Obligation: Member Notice of Discharge

A special type of appeal applies only to hospital discharges. Hospitals affected by these instructions include any facility providing care at the inpatient hospital level. Inpatient hospital care would include: short term, long term, acute or non-acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care, or providing a broader spectrum of services, and acute and non-acute access hospitals. Under this heading, hospitals would also include: Indian Health Service hospitals, Medicare dependent hospitals, rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children’s hospitals, and cancer hospitals. Swing beds in hospitals are excluded, because they are considered a lower level of care.

Hospitals must notify Medicare members who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use the CMS form entitled Important Message from Medicare (IM) to explain the member’s rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his/her representative and provide a copy at that time. Hospitals should deliver this notice as far in advance as possible but no less than 2 days before discharge. If the member requests an appeal a Detailed Notice of Discharge must be issued to the member. Copies of the IM and Detailed Notice of Discharge have been included with these instructions. Refer to page S 19-21 for the IM and Detailed Notice of Discharge.

The IM and Detailed Notice of Discharge forms and further guidance on this ruling can be found at the following internet address: http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp.
### Appeals and Grievances, continued

If Blue Medicare Advantage (PPO) denies the Member’s appeal in whole or part, Blue Medicare Advantage (PPO) will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of Blue Medicare Advantage (PPO). This organization will review the appeal and, if the appeal involves authorization for health care, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the appeal involves an expedited reconsideration decision, the IRE will make the decision within 72 hours.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the Member may appeal to an Administrative Law Judge (ALJ). If the Member is not satisfied with the ALJ’s decision, the Member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the Member may be able to request Judicial Review.

### Detailed Notice of Discharge

A special type of appeal applies only to hospital discharges. Hospitals must notify Medicare beneficiaries and Medicare Advantage (MA) plan enrollees about their appeal rights and general liability. This will be accomplished by the hospital issuing the CMS form Important Message from Medicare (IM) from Medicare within two calendar days of admission and obtaining the signature of the patient or representative to indicate his/her understanding. The hospital will provide a copy to the patient/representative and keep a copy for the facility.

If the beneficiary or the beneficiary's representative does not agree with the hospital's discharge decision, the beneficiary or the representative may appeal the decision. The request for review must be made by midnight of the day of discharge. If the request is made after the deadline, the request will be accepted, however, the beneficiary is not protected from financial liability. Upon notification of the appeal, the hospital is required to complete the Detailed Notice of Discharge (CMS Form 1006, see Appendix). The IM and Detailed Notice of Discharge forms and further guidance on this ruling can be found at the following internet address:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp
Appeals and Grievances, continued

Another special type of appeal applies only to a Member dispute regarding when coverage will end for skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). The DENC is a standardized written notice that provides specific, and detailed information to Medicare enrollees concerning why their SNF, HHA, or CORF services are ending (see Appendix). The Medicare health plan (or the provider by delegation) must issue the DENC to the enrollee (with a copy provided to the QIO) whenever an enrollee appeals a termination decision about their SNF, HHA or CORF services. The DENC must include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;

- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the enrollee may obtain a copy of the Medicare policy from the Medicare health plan;

- Any applicable Medicare health plan policy, contract provision, or rationale upon which the termination decision was based; and

- Facts specific to the enrollee and relevant to the termination decision that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee’s case.

Medicare health plans (or providers by delegation) must issue the DENC to enrollees and provide a copy to the QIO no later than close of business (typically 4:30 P.M.) of the day the QIO notifies the Medicare health plan that the enrollee requested an appeal.

Participating Facility Obligations – Organization Determinations

At each patient encounter with a Blue Medicare Advantage (PPO) Member, the Participating Facility must notify the Member of his or her right to receive, upon request, a detailed written notice from Blue Medicare Advantage (PPO) regarding the Member’s services. The Participating Facility’s notification must provide the Member with the information necessary to contact Blue Medicare Advantage (PPO) and must comply with any other requirements specified by Centers for Medicare & Medicaid Services (CMS). If a Member requests Blue Medicare Advantage (PPO) to provide a detailed notice of a Participating Provider’s decision to deny a service in whole or part, Blue Medicare Advantage (PPO) must give the Member a written notice of the determination.
Appeals and Grievances, continued

Participating Facilities must also cooperate with Blue Medicare Advantage (PPO) and Members in providing necessary information to resolve the appeals within the required time frames. Participating Facilities must provide the pertinent medical records and any other relevant information. In some instances, Participating Facilities must provide the records and information very quickly in order to allow Blue Medicare Advantage (PPO), the IRE or QIO to make an expedited decision.

Note: Except for requests for expedited appeals, a Participating Facility may not request an appeal on behalf of a Member.
Members’ Rights and Responsibilities

Timely, Quality Care

Blue Medicare Advantage (PPO) Members have the right to timely, quality care, and treatment with dignity and respect. Participating Facility must respect the rights of all Blue Medicare Advantage (PPO) Members. Specifically, Blue Medicare Advantage (PPO) Members have been informed that they have the following rights and responsibilities:

- Choice of a qualified Participating Physician and Hospital.
- Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to Participating Physician.
- To receive Emergency Services when the Member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive Urgently Needed Services when traveling outside Blue Medicare Advantage (PPO)’s Service Area or in Blue Medicare Advantage (PPO)’s Service Area when unusual or extenuating circumstances prevent the Member from obtaining care from a Participating Provider.
- To request the number of grievances and appeals and dispositions in aggregate.
- To request information regarding physician compensation.
- To request information regarding the financial condition of Blue Medicare Advantage (PPO).
### Members’ Rights and Responsibilities, continued

**Treatment with Dignity and Respect**

- To be treated with dignity and respect and to have their right to privacy recognized.
- To exercise these rights regardless of the Member’s race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To confidential treatment of all communications and records pertaining to the Member’s care.
- To access, copy and/or request amendment to the Member’s medical records consistent with the terms of HIPAA.
- To extend their rights to any person who may have legal responsibility to make decisions on the Member’s behalf regarding the Member’s medical care.
- To refuse treatment or leave a medical facility, even against the advice of physicians (providing the Member accepts the responsibility and consequences of the decision).
- To complete an Advance Directive, living will or other directive to the Member’s medical providers.

**Member Satisfaction**

Blue Medicare Advantage (PPO) periodically surveys Members to measure overall customer satisfaction as well as satisfaction with the care received from Participating Facilities. Survey information is reviewed by Blue Medicare Advantage (PPO) and results are shared with the Participating Facilities.

**Services Provided in a Culturally Competent Manner**

Blue Medicare Advantage (PPO) is obligated to ensure that services are provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating Facility must cooperate with Blue Medicare Advantage (PPO) in meeting this obligation.
Blue Medicare Advantage (PPO) Members have the right to complete an “Advance Directive” statement. This statement indicates, in advance, the Member’s choices for treatment to be followed in the event the Member becomes incapacitated or otherwise unable to make medical treatment decisions. Blue Medicare Advantage (PPO) suggests that Participating Providers have Advance Directive forms in their office and available to Members.

Blue Medicare Advantage (PPO) tracks all complaints and grievances to identify areas of improvement for Blue Medicare Advantage (PPO). This information is reviewed by the Quality Improvement Committee.
Obligation to Provide Access to Care

All Participating Providers and hospitals will treat all Blue Medicare Advantage (PPO) Members with equal dignity and consideration as their non-Blue Medicare Advantage (PPO) patients.

Neither Blue Medicare Advantage (PPO) or Participating Providers may deny, limit, or condition the coverage or furnishing of services to Members on the basis of any factor that is related to health status, including, but not limited to the following:

1. Medical condition, including mental as well as physical illness;
2. Claims experience;
3. Receipt of health care;
4. Medical history;
5. Genetic information;
6. Evidence of insurability, including conditions arising out of acts of domestic violence;
7. Disability;
8. Race, ethnicity, national origin;
9. Religion;
10. Sex, sexual orientation;
11. Age;
12. Mental or physical disability;
13. Source of payment; and

Provider’s office must have policies and procedures noting above.

Participating providers must have policies demonstrating they accept for treatment any member in need of health care services they provide.
# Glossary of Terms
*(For use in this Blue Medicare Advantage (PPO) Supplement Only)*

<table>
<thead>
<tr>
<th>Appeal</th>
<th>Any of the procedures that deal with the review of adverse organization determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service. These procedures include reconsiderations by Blue Medicare Advantage (PPO), an independent review entity (IRE), hearings before Administrative Law Judge (ALJ), review by the Medicare Appeals Council, and Federal judicial review.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>All health care services that are covered under the Medicare Part A and Part B programs except hospice services and additional benefits. All Members of Blue Medicare Advantage (PPO) receive all Basic Benefits.</td>
</tr>
<tr>
<td>Center for Health Dispute Resolution (CHDR)</td>
<td>An independent CMS contractor that reviews appeals by Members of Medicare managed care plans, including Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>The Centers for Medicare &amp; Medicaid Services, the Federal Agency responsible for administering Medicare.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Those benefits, services or supplies which are:</td>
</tr>
<tr>
<td></td>
<td>• Provided or furnished by Participating Providers or authorized by Blue Medicare Advantage (PPO) or its Participating Providers.</td>
</tr>
<tr>
<td></td>
<td>• Provided or furnished by non-Participating Providers at the in-network benefit level when authorized by Blue Medicare Advantage (PPO) due to network inadequacy or continuity of care concerns.</td>
</tr>
<tr>
<td></td>
<td>• Provided or furnished by non-Participating Providers at the out of network benefit level.</td>
</tr>
<tr>
<td></td>
<td>• Emergency Services and Urgently Needed Services that may be provided by non-Participating Providers.</td>
</tr>
<tr>
<td></td>
<td>• Renal dialysis services provided while the Member is temporarily outside the Service Area.</td>
</tr>
<tr>
<td></td>
<td>• Basic and Supplemental Benefits.</td>
</tr>
<tr>
<td>Emergency Medical Condition</td>
<td>Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:</td>
</tr>
</tbody>
</table>
**Glossary of Terms, continued**  
*(For use in this Blue Medicare Advantage (PPO) Supplement Only)*

| **Emergency Medical Condition, continued** | • Serious jeopardy of the patient’s health;  
| | • Serious impairment to bodily functions;  
| | • Serious dysfunction of any bodily organ or part;  
| | • Serious disfigurement; or  
| | • Serious jeopardy to the health of the fetus, in the case of a pregnant patient. |
| **Emergency Services** | Covered inpatient or outpatient services that are:  
| | • furnished by a Provider qualified to furnish Emergency Services; and  
| | • needed to evaluate or stabilize an Emergency Medical Condition. |
| **Experimental Procedures and Items** | Items and procedures determined by Blue Medicare Advantage (PPO) and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Blue Medicare Advantage (PPO) will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare. |
| **Facility** | Hospital and Ancillary Provider which include but is not limited to:  
| | • Durable Medical Equipment Supplier  
| | • Skilled Nursing Facility |
| **Fee-for-Service Medicare** | A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare). |
| **Grievance** | Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are: waiting times in physician offices; and rudeness or unresponsiveness of Customer Service Staff. |
| **Home Health Agency** | A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when Medically Necessary, when Members are confined to the Member’s home and when authorized by their Primary Care Physician. |
| **Hospice** | An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families |
| **Hospital** | A Medicare-certified institution licensed in the state of Texas, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living. |
| **Independent Physicians Association (IPA)** | A group of physicians who function as a Participating Medical Provider/Group yet work out of their own independent medical offices. |
| **Medically Necessary** | Medical Services or Hospital Services that are determined by Blue Medicare Advantage (PPO) to be: |
| | • Rendered for the diagnosis or treatment of an injury or illness; and |
| | • Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and |
| | • Not furnished primarily for the convenience of the Member, the attending Participating Provider, or other Provider of service. |
| **Medicare** | The Federal Government health insurance program established by Title XVIII of the Social Security Act. |
| **Medicare Part A** | Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare. |
| **Medicare Part A Premiums** | Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If Members are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, island or local government employment to be insured, Members do not have to pay a monthly premium. If Members do not qualify for premium-free Part A benefits, Members may buy the coverage from Social Security if Members are at least 65 years old and meet certain other requirements. |
**Medicare Part B**

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

**Medicare Part B Premium**

A monthly premium paid to Medicare (usually deducted from a Member’s Social Security check) to cover Part B services. Members must continue to pay this premium to Medicare to receive Covered Services whether Members are covered by a Medicare Advantage Plan or by original Medicare.

**Medicare Advantage (MA) Plan**

A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit Plan in the same Service Area. Blue Medicare Advantage (PPO) is a Medicare Advantage plan.

**Member**

The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in the Blue Medicare Advantage (PPO) and whose enrollment has been confirmed by CMS.

**Non-Participating Medical Provider or Facility**

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract to deliver Covered Services to Blue Medicare Advantage (PPO) Members.

**Participating Hospital**

A Hospital that has a contract to provide services and/or supplies to Blue Medicare Advantage (PPO) Members.

**Participating Medical Group**

Physicians organized as a legal entity for the purpose of providing medical care. The Participating Medical Group has an agreement to provide medical services to Blue Medicare Advantage (PPO) Members.

**Participating Pharmacy**

A pharmacy that has an agreement to provide Blue Medicare Advantage (PPO) Members with medication(s) prescribed by the Members’ Participating Provider in accordance with Blue Medicare Advantage (PPO).
Participating Provider

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas and Medicare to deliver or furnish health care services. This individual or institution has a written agreement to provide services directly or indirectly to Blue Medicare Advantage (PPO) Members pursuant to the terms of the Agreement.

Service Area

A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. The approved state of Texas Service Area for Blue Medicare Advantage (PPO) includes the following counties:

- **Austin area** – Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson.
- **Dallas area** – Collin, Dallas, Denton and Tarrant.
- **Houston area** – Chambers, Fort Bend, Hardin, Harris, Jefferson, Liberty, and Montgomery.
- **San Antonio area** – Bexar.

Urgently Needed Services

Covered Services provided when the Member is temporarily absent from the Blue Medicare Advantage (PPO) Service Area when such services are Medically Necessary and immediately required as a result of an unforeseen illness, injury, or condition.

NOTE: If you have any questions regarding the definitions listed above or any other information listed in this manual, contact your Facility Provider Network Office or Representative.
Blue Medicare Advantage (PPO) Key Contacts List

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Medicare Advantage (PPO) Provider Customer Service</td>
<td>877-774-8592 (M – F 8:00 a.m. – 8:00 p.m. (CST))</td>
</tr>
<tr>
<td><strong>Utilization Management (UM)</strong></td>
<td></td>
</tr>
<tr>
<td>• Preauthorization</td>
<td></td>
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<tr>
<td>• iExchange On-line Access</td>
<td><a href="http://www.bcbstx.com/provider">www.bcbstx.com/provider</a></td>
</tr>
<tr>
<td>• Preauthorization</td>
<td>877-774-8592 (M-F 8 am – 5 pm CT)</td>
</tr>
<tr>
<td>(if iExchange system is unavailable)</td>
<td></td>
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<tr>
<td>• Medical Coverage Determinations Fax</td>
<td>855-874-4711</td>
</tr>
<tr>
<td>• Medical Appeals Fax</td>
<td>855-674-9185</td>
</tr>
<tr>
<td>• Medical Grievances Fax</td>
<td>855-674-9189</td>
</tr>
<tr>
<td>All Medical Grievances &amp; Appeals and Medical</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>Coverage Determinations &amp; Appeals (mail)</td>
<td>Appeals &amp; Grievances</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 4288</td>
</tr>
<tr>
<td></td>
<td>Scranton, PA 18505</td>
</tr>
<tr>
<td>Clinical Pathology Laboratories (CPL)</td>
<td>800-595-1275</td>
</tr>
<tr>
<td>• CPL’s Website Address</td>
<td><a href="http://www.cpllabs.com">www.cpllabs.com</a></td>
</tr>
<tr>
<td>Electronic/Paper Claim Questions or Problems</td>
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</tr>
<tr>
<td>• Availity</td>
<td>800-282-4548</td>
</tr>
<tr>
<td>• Web site Address</td>
<td><a href="http://www.availity.com">www.availity.com</a></td>
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<tr>
<td>Blue Medicare Advantage (PPO) Claims Address</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>(For submission of paper claims)</td>
<td>P.O. Box 660044</td>
</tr>
<tr>
<td></td>
<td>Dallas, Texas 75266-0044</td>
</tr>
<tr>
<td>All Other Correspondence</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 4555</td>
</tr>
<tr>
<td></td>
<td>Scranton, PA 18505</td>
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<tr>
<td></td>
<td>Or fax to 855-674-9192</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td></td>
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<tr>
<td>• Customer Service</td>
<td>877-774-8592</td>
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<tr>
<td>• Case Management</td>
<td>855-390-6567</td>
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<tr>
<td>Provider Status</td>
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<td>(To verify, access the On-line Provider Directory)</td>
<td><a href="http://www.bcbstx.com/provider/medicare/indexhtm">www.bcbstx.com/provider/medicare/indexhtm</a></td>
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<td>CMS Web site Address</td>
<td><a href="http://www.cms.gov">www.cms.gov</a></td>
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