The Blue Book℠
Blue Medicare HMO℠
Blue Medicare PPO℠

Supplemental Guide | Provider e-Manual

BlueCross BlueShield of North Carolina

MEDICARE

Visit ***BlueCrossNC.com/Medicare***

U37164, 5/21

The Blue Book℠
BlueMedicare HMO℠
BluePPO℠

Supplemental Guide

Edition: May 2021

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) and its corporate affiliates are Medicare Advantage organizations with Medicare contracts to provide HMO, PPO and DSNP plans.

Please note:

In the event of any inconsistency between information contained in this manual and the agreement(s) between you and Blue Cross NC, the terms of such agreement(s) shall govern. Also, please note that Blue Cross NC may provide available information concerning an individual's status, eligibility for benefits and/or level of benefits. The receipt of such information shall in no event be deemed to be a promise or guarantee of payment, nor shall the receipt of such information be deemed to be a promise or guarantee of eligibility of any such individual to receive benefits. Further, presentation of Blue Medicare HMO and/or Blue Medicare PPO identification cards in no way creates, nor serves to verify an individual's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Member's actual Blue Medicare℠ eligibility and benefits should always be verified in advance of providing services.

To view pdf documents, you will need Adobe Acrobat Reader. If you do not have it already, you can access the website for Adobe directly at *adobe.com/products/acrobat/readstep2.html*.

Table of Contents

Continued ▶

Continued ▶

Service area, ID cards and provider verification of membership

4

Participating physician responsibilities

5

Continued ▶

Quality Improvement program 6

Emergency care coverage 7

Utilization Management programs 8

Continued ▶

Utilization Management programs (continued) 8

Prior authorization requirements 9

Pre-admission certification 10

Continued ▶

Case Management 11

Medical guidelines 12

Claims billing and reimbursement 13

Continued ▶

Continued ▶

Continued ▶

Pharmacy and specialty networks 14

Continued ▶

Post-service provider appeals 15

Member appeal and grievance procedures 16

Member rights and responsibilities 17

Continued ▶

Sanction process 18

Credentialing 19

Marketing, advertising and brand regulations 20

Continued ▶

Health Insurance Portability and Accountability Act (HIPAA) 21

Privacy and confidentiality 22

Medicare Advantage and Part D Compliance 23

Forms 24

Continued ▶

Healthy Blue + Medicare℠ Dual-Eligible Special Needs Plan

25

Glossary of terms

26

1

Introduction

1.1
About this manual

We are pleased to provide you with a newly updated and comprehensive Blue Book Provider Manual – Blue Medicare HMO and Blue Medicare PPO Supplemental Guide, for providers participating in the Blue Cross NC provider network. This manual has been designed to make sure that you and your office staff have the information necessary to effectively understand and administer Blue Medicare HMO and Blue Medicare PPO member health care benefit plans.

Blue Cross NC is an HMO/PPO/PDP (Rx) plan with a Medicare contract.

Blue Cross NC's goal is that all Blue Cross NC members are provided quality health care, including preventive care, by an ample, accessible network of participating providers. We want to work with all participating Blue Cross NC providers and their staff to reach that goal. Each HMO member electing Blue Medicare coverage must choose a primary care physician who is responsible for coordinating his/her care. PPO members are strongly encouraged to choose a primary care physician. Blue Cross NC strives to offer our members the advantages of a primary care physician and access to a broad panel of qualified specialists, hospitals, ambulatory care facilities and non-physician providers.

Blue Cross NC offers several resources for providers and their staff. Our provider network staff is responsible for providing ongoing support to participating providers' office staff and is available at any time to answer questions and/or direct inquiries to other Blue Cross NC departments. Our health care services staff of experienced nurses work with physician offices on a regular basis for pre-certification, Case Management, Utilization Review and quality improvement issues. Blue Cross NC Customer Service representatives are available for general billing, claims or benefit questions. Representatives may be reached at The Provider Line (**1-800-777-1643**) and will assist you and your staff in obtaining information that is important in managing your Blue Medicare HMO and Blue Medicare PPO patient population.

Additional provider information is available on the Blue Cross NC website's provider section.

Medical Directors are available if Blue Cross NC physicians have medical or procedural questions. When contacting Care Management for a prior authorization, providers can request that a nurse assist in coordinating a discussion with the Medical Director as part of the review process. Our goal is to be responsive to participating physicians as they serve Blue Medicare HMO and Blue Medicare PPO members in their practices. We believe that your participation in Blue Cross NC provider network is integral to our success. Our commitment is to work with providers to continually improve our health care delivery system.

We would like to highlight several items that may be of importance to you and the chapters in which to find them:

- Phone numbers for contacting Blue Cross NC – **Chapter 2**
- Health benefit plans and sample identification cards – **Chapter 4**
- Prior authorization requirements – **Chapter 9**
- Information about the Medicare Advantage and Part D compliance programs at Blue Cross NC and hotline numbers for reporting fraud, waste, abuse or ethics concerns – **Chapter 23**

As referenced in your participation agreement, this Provider Manual Supplemental Guide is intended to supplement the agreement between you and Blue Cross NC. Nothing contained in this Provider Manual Supplemental Guide is intended to amend, revoke, contradict or otherwise alter the terms and conditions of the participation agreement. If there is an inconsistency between the information contained in this manual and the participation agreement, the terms of the participation agreement shall govern.

If there is an inconsistency between the participation agreement and the member certificate, the member certificate shall govern.

All codes and information are current as of the manual proofing date but could change based on new publications and policy changes.

Changes will be communicated through but not limited to the mail, emails and the website ***BlueCrossNC.com/provider-home***.

Note: To get Blue Cross NC's latest news and information affecting providers, join our email registry by visiting us at ***BlueCrossNC.com/providers/forms-and-documentation/provider-email-registry***.

1.2
Provider Manual – Blue Medicare HMO and Blue Medicare PPO Supplemental Guide online

The Blue Book Provider Manual Blue Medicare HMO and Blue Medicare PPO Supplemental Guide is maintained on the Blue Cross NC website for providers at ***BlueCrossNC.com/node/4471***. The manual is available to providers for download to their desktop computers for easy and efficient access.

The process to view is easy: Just click on The Blue Book Provider Manual – Blue Medicare HMO and Blue Medicare PPO Supplemental Guide hyperlink and select the option to open.

If you want to save a copy of the manual to your computer's desktop, open the manual for viewing following the same instructions above. After you have opened the manual to view, just select "File" from your computer's tool bar, and select the option to "Save a Copy." Then, decide where you want to keep your updated edition of the Provider Manual Supplemental Guide on your computer, and click on the button to save.

If you experience any difficulty accessing or opening The Blue Book from our website or would like to receive the manual in another format, please contact the provider network (contact information is available in **Chapter 2** of this manual).

Important: Please note that providers are reminded that this Manual Supplemental Guide will be periodically updated, and to receive accurate and up-to-date information from the most current version, providers are encouraged to always access the provider manual in the "Providers" section of the Blue Cross NC website at ***BlueCrossNC.com/node/4471***.

1.3
Feedback

This manual is your main source of information on how to administer Blue Cross NC Blue Medicare HMO and Blue Medicare PPO plans. If you cannot find the specific information that you need within the manual, please utilize the following resources:

- Your health care business's provider agreement with Blue Cross NC
- The Blue Cross NC website ***BlueCrossNC.com/provider-home***
- Blue Cross NC Provider Blue Line℠ at **1-800-777-1643**
- Your provider network office as listed in **Chapter 2, Contacting Blue Cross NC and general administration**
- HIPAA companion guide located on the website at ***BlueCrossNC.com/provider-home***
- Blue Cross NC formulary information on the website at ***BlueCrossNC.com/provider-home***

2

Contacting Blue Cross NC and general administration

2.1
Provider line – 1-888-296-9790

The Provider Line is available to assist providers with:

- Routing inquiries to the appropriate representative only when it is necessary to speak with a representative
- Identifying claims status for each claim when providers file multiple claims for the same patient for the same date of service
- Providing information relevant to claims payments such as coinsurance amounts, check numbers and check dates
- Providing eligibility and benefit information including effective and termination dates of coverage, and deductibles met for current and prior year
- Providing current and future primary care physician assignment name and telephone number
- Identifying multiple members with the same date of birth to make sure the information is provided for the correct patient
- Providing Blue Cross NC address information
- Locating prior plan approval status – approved / denied / currently in review / unable to locate request
- Providing referral status

Before calling the Provider Line, have the following information available:

- Patient's identification number
- Patient's date of birth (mm/dd/yyyy)
- Date of service (mm/dd/yyyy)
- Amount of charge ($0.00)

Note: **Blue *e*℠** and the Provider Line are the most accurate and up-to-date resources for verifying claim status. **Blue *e*** allows providers to access eligibility, authorization and claim information from the convenience of their computer screen and is faster than making a phone call.

2.2
Written provider claim inquiry

One alternative to the Provider Line for claims status information is the provider claim inquiry form (see **Chapter 24, Forms**). Providers may make copies of the form from this manual and send to one (1) of the addresses below. Use of this form will allow:

- Reconsideration of a paid or denied claim for professional services that were billed on a CMS-1500 claim form or other similar forms
- Request for review of an incorrectly paid claim for professional services that were billed on a CMS-1500 claim form or other similar forms
- Request for information regarding denial of services not included in a member's health benefit plan
- Requests for the status of filed claims
- Refund of overpayments
  (**Note:** There is a different mailing address for refund of overpayments; see below)

Before calling the Provider Line, have the following information available:

- Patient's identification number
- Patient's date of birth (mm/dd/yyyy)
- Date of service (mm/dd/yyyy)
- Amount of charge ($0.00)

The completed provider claim inquiry should be faxed to 1-336-659-2962 or mailed to:

Blue Cross and Blue Shield of North Carolina
P.O. Box 17509
Winston-Salem, NC 27116

Refund of overpayments ONLY should be mailed to:

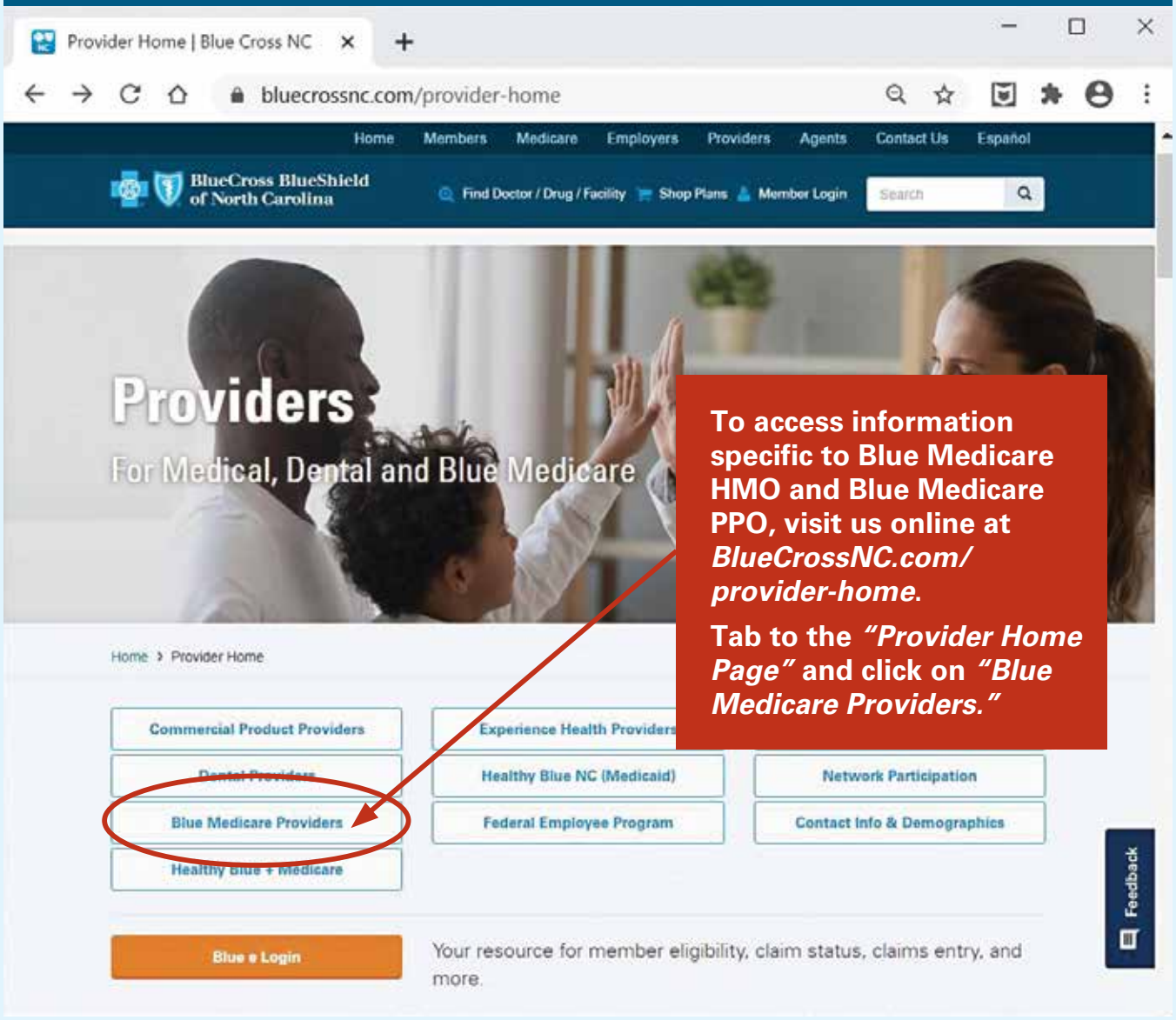
Blue Cross and Blue Shield of North Carolina
P.O. Box 30048
Durham, NC 27702

2.3
Online availability

For Questions Regarding	
Blue *e* Provider directory assistance HIPAA companion Provider education information	Visit ***BlueCrossNC.com/provider-home***
Medical oncology	**Blue *e*** at ***BlueCrossNC.com/providers/esolutions/electronic-solutions*** to access AIM's web-based application ProviderPortal℠
Formulary	Visit ***BlueCrossNC.com/provider-home***
naviHealth (Skilled Nursing Facility Admissions)	Visit ***BlueCrossNC.com/providers/blue-medicare-providers/skilled-nursing-facility-admissions***

Continued ▶

Contact us on the web at *BlueCrossNC.com/provider-home*



To access information specific to Blue Medicare HMO and Blue Medicare PPO, visit us online at *BlueCrossNC.com/provider-home*.

Tab to the *"Provider Home Page"* and click on *"Blue Medicare Providers."*

2.4
Blue Cross NC office telephone numbers and fax numbers

Services	Phone	Fax
General information / sales	**1-800-665-8037**	**1-336-659-2963**
Provider information line	**1-888-296-9790**	**1-336-659-2963**
HMO Member Customer Service	**1-888-310-4110**	**1-336-659-2963**
PPO Member Customer Service	**1-877-494-7647**	**1-336-659-2963**
Case Management	**1-877-672-7647**	**1-336-794-1556**
Special Investigations Unit (SIU)	**1-800-324-4963**	
Authorizations / Pre-certification (includes Care Management – utilization review and pre-certification) and Episodic Care Management, (e.g. HH, acute inpatient rehabilitation, prosthetics, motorized wheelchair)	**1-888-296-9790**	**1-336-794-1556**
Discharge planning / concurrent review	**1-888-296-9790**	**1-336-794-1556**

2.5
AIM Specialty Health (AIM) and naviHealth telephone and fax numbers

Services	Phone	Fax
AIM – Medical Oncology	**1-866-455-8414**	**1-800-610-0050**
naviHealth – Provider information line	**1-844-801-3686**	**1-855-847-7242**

2.6
Mailing addresses for Blue Cross NC Blue Medicare HMO and Blue Medicare PPO

Main Mailing Address	Main Shipping Address
Blue Cross and Blue Shield of North Carolina **P.O. Box 17509** **Winston-Salem, NC 27116-7509**	**Blue Cross and Blue Shield of North Carolina** **5600 University Parkway** **Winston-Salem, NC 27105-1312**

Claims for Blue Medicare members should be submitted electronically (or by paper when necessary) to Blue Cross NC. Claims sent in error for Blue Medicare HMO and Blue Medicare PPO members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

2.7
Blue Cross NC Provider Network

The Blue Cross NC provider network department is responsible for developing and supporting relationships with physicians and other practitioners, acute care hospitals, specialty hospitals, ambulatory surgical facilities and ancillary providers. Provider network's staff are dedicated to serve as a liaison between you and Blue Cross NC, and they are available to assist your organization. Please contact the provider network for contract issues, fee information and educational needs.

Address	Phone	Fax	Email
Blue Cross NC Provider Network **P.O. Box 2291** **Durham, NC 27702-2291**	**1-800-777-1643**	**1-919-765-4349** Provider address changes: **1-336-794-8866**	*ProviderUpdates@bcbsnc.com*

Provider network staff is available to assist you Monday through Friday, 8 a.m. until 5 p.m. ET.

Blue Cross NC Contractual Notices

Blue Cross NC will send contractual notices to the practice mailing address of record, if provided. If the practice mailing address is not provided, then we will use the primary physical address of record.

2.8
Changes to your office and/or billing information

Contact the provider network by phone, mail, fax or email to request changes to office and/or billing information (e.g., physical address, telephone number, etc.) by sending a written request signed by the physician or office billing manager to the address or fax number on the previous page. Changes may include the following:

- Name and address of where checks should be sent
- Name changes, mergers or consolidations
- Group affiliation
- Physical address
- Federal tax identification number (attach W9 form)
- National Provider Identifier (NPI)

3

Administrative policies and procedures

Blue Medicare HMO and Blue Medicare PPO are offered by Blue Cross and Blue Shield of North Carolina, and its corporate affiliates under Medicare contracts with CMS. Blue Cross NC does not discriminate based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, health status, claims experience, receipt of health care, medical history and medical condition including physical and mental illness, genetic information, evidence of insurability, source of payment or demographic location as defined by CMS. All qualified Medicare beneficiaries may apply. Members must be entitled to Medicare Part A, enrolled in Medicare Part B and reside in the CMS-approved service area. Some limitations and restrictions may apply.

3.1
Participating provider responsibilities

3.1.1
Basic principles

Blue Cross NC participating providers are responsible for providing quality health care to our members according to the standards of care of the community, the medical profession and the various professional organizations and certifying boards. Blue Cross NC has certain policies and guidelines and frequently makes decisions regarding coverage of services; however, these are not intended to be treatment decisions and do not obviate or supersede the responsibility of the physician to provide quality care, acting in the patient's best interest, in each individual case.

All providers who agree to participate as Blue Cross NC providers accept responsibility for the provision of appropriate medical care according to Blue Cross NC policies and guidelines, and in keeping with the standards of care described in the previous paragraph of this section.

Blue Cross NC Primary Care Physicians (PCP)

Blue Cross NC primary care physicians are responsible for providing or arranging for all appropriate medical services for Blue Cross NC members. Blue Cross NC relies on primary care physicians to decide when specialist care is necessary or when other services such as medical equipment are indicated. To serve as a member's PCP, providers must be credentialed by Blue Cross NC as a PCP.

Typically, the following provider types that specialize in primary medicine may serve as a PCP:

- Family practitioner
- Internist
- Gerontologist
- General practitioner
- Pediatrician (for those under eighteen [18] years of age)

In some cases, a specialist, such as an OB/GYN or an oncologist, may serve as a PCP.

Blue Cross NC specialists

Blue Cross NC specialists are expected to render high quality care appropriate to the needs of Blue Cross NC members requiring specialized treatment.

Dual-eligibility

If the provider meets Blue Cross NC credentialing standards for both a primary care physician and a specialist physician with respect to Blue Cross NC members, the member may elect to designate him or her as both a primary care physician and a specialist physician as approved by Blue Cross NC. Contact network management for details at **1-800-777-1643.**

3.1.2
Criteria for selection and listing as a specialist or sub-specialist

In order to be selected and listed in Blue Cross NC's provider directory as a medical specialist or sub-specialist (excluding general practice), one (1) of the following criteria must be met:

1. The applicant must be board-certified by a certifying board of the American Medical Association and/or the American Board of Medical Specialties.
2. The applicant must be board-qualified for a specialty or sub-specialty as defined by the appropriate certifying board for a period of not more than three (3) years following completion of training, unless otherwise defined by the board.
3. The applicant must be board-qualified within a three (3) year period following completion of board qualification.
4. The applicant must present special documentation justifying listing as a specialist.

3.1.3
Primary care physician-patient relationship

The primary care physician-patient relationship for Blue Cross NC members begins at the time the member selects the physician to be his or her primary care physician, and coverage for medical services becomes effective. From that time on, unless the relationship is terminated, the physician is responsible for providing necessary medical care, including emergency care. This includes a member who is new to a practice, even if the patient has not made previous contact with that office.

Individual requirements for obtaining medical records, initial physicals and/or other initial contact with the physician's office may be instituted by a physician but does not alter the responsibility for providing services when the need arises.

If a physician chooses to terminate a physician-patient relationship, either for cause or change in the physician's availability, Blue Cross NC must receive sixty (60) days notice. The member must be given a thirty (30) day written notice by Blue Cross NC in order to select another primary care physician. During the thirty (30) day period following receipt of the notice to the member from Blue Cross NC, the physician remains responsible for emergency and/or urgent care for the member. A copy of the termination notice must be sent to the Blue Cross NC provider network department.

Practice limitations

Provider agrees to give Blue Cross NC thirty (30) days prior written notice regarding the limitations or closing of their practice or the practice of any participating physician. The provider also agrees to notify Blue Cross NC members regarding the practice and or provider's participation status.

Availability and coverage

Participating physicians, primary care and specialist, should be available to their patients when needed. When the physician's office is closed, the members should have a clear and readily available access pathway for needed care. Usually this will be through an answering service.

Coverage for members in the event of the physician's absence should be arranged with a Blue Cross NC participating physician if possible. If coverage is arranged with a non-participating physician, the participating physician is responsible for insuring that the covering physician agrees to provide services to Blue Cross NC members according to Blue Cross NC policies, accepts Blue Cross NC compensation according to Blue Cross NC fee schedule, and bills only Blue Cross NC for covered services (i.e., patients should be billed only for appropriate copayments or coinsurance).

3.1.4
Reimbursement and billing

What the provider can collect

Participating providers agree to bill only Blue Cross NC for all covered services for Blue Cross NC members, collecting only appropriate copayments or coinsurance from the member. Blue Cross NC members are directly obligated only for the copayment/coinsurance amounts indicated on their member card (in their Evidence of Coverage) and, payment for non-covered services for which Blue Cross NC has issued an organization determination denying coverage, and payment for services after the expiration date of the member's coverage. The provider should not collect any deposits and does not have any other recourse against a Blue Cross NC member for covered services.

In the event the participating provider provides services which are not covered by the Plan, he or she will not seek any payment from the patient other than the copayment/coinsurance amounts indicated on the member card (and in their Evidence of Coverage) unless, prior to the provision of such non-covered services, Blue Cross NC has issued an organization determination to the patient denying coverage. Blue Cross NC shall make the relevant terms and conditions of each plan reasonably available to participating providers.

Submission of claims

Claims should be submitted using CMS-1500 claim form or other similar forms; or UB-04 form. To file an electronic claims submission, please refer to **Section 13.1, General filing requirements**, for information on how to get set up to file electronically.

The provider is responsible for proper submission of claims for compensation of services rendered. The guidelines in the current AMA CPT and HCPCS code books and ICD-10-CM must be used for coding. Selection of the procedure and evaluation and management codes should be appropriate for the specific service rendered as is documented in the patient's medical record.

3.1.5
Self-pay for privacy

See **Chapter 22** of this manual for important information regarding self-pay for privacy.

3.1.6
Utilization Management

Blue Cross NC Utilization Management charter and annual work plan are reviewed and approved by a Physician Advisory Group comprised of participating physicians, the associate Medical Director, the Director of Care Management and Blue Cross NC staff. The policy relative to a specific procedure or pre-certification requirement may be obtained by contacting Blue Cross NC Care Management.

All Blue Cross NC providers participate in the Blue Cross NC Utilization Management process by providing appropriate medical care and complying with Blue Cross NC administrative guidelines and required provider activities. These include:

1. Prior authorization requirements for admissions (**Chapter 9**) and certain procedures (**Chapter 10**).
2. Prior authorization requirements for durable medical equipment and certain pharmaceuticals (**Chapters 9 and 14**).
3. Participation in the Blue Cross NC Case Management program when applicable (**Chapter 11**).
4. Requirements for providers to supply relevant information at the time of the request, adequate information to permit concurrent review for patients in an inpatient level of care and medical services.

3.1.7
Quality Management

Blue Cross NC relies on its participating physicians to deliver medical care of high quality. Blue Cross NC is required to document and demonstrate that medical care provided for our members is of acceptable quality.

The Blue Cross NC Quality Management program monitors potential quality of care events, patient complaints about quality of care, and assesses performance in certain areas periodically.

When necessary, a complaint or potential quality problem is presented to the credentialing committee. The decisions of Blue Cross NC Associate Medical Director or credentialing committee may be any of the following:

1. No action is necessary.
2. The single event may or may not indicate a problem; the item is filed in the provider's file for reference and to detect trends, if present.
3. The medical care provided is below standard and remedial action is indicated. Institution of the sanction process, however, is not warranted.
4. The medical care provided is below standard and warrants instituting the sanction process.

The provider involved would be notified of decision numbers three (3) or four (4); however, notification is not considered necessary for numbers one (1) or two (2).

All items reviewed are placed in the provider's file and made available to the credentialing committee at the time of recredentialing.

3.1.8
Use of physician extenders and assistants

Blue Cross NC understands and encourages the use of physician assistants, nurse practitioners and other nursing and specially trained personnel. The physician and the extender are expected to comply with all applicable statutes and regulations as appropriate for the practice site. Claims filing guidelines are determined by the terms of the participating provider agreement with Blue Cross NC.

3.1.9
Advance directives

On December 1, 1991, the requirements for advance directives in the Omnibus Budget Reconciliation Act of 1990, or "OBRA 1990," took effect. As of that date, Medicare and Medicaid certified hospitals and other health care providers (such as prepaid health plans [HMOs]) must provide all adult members with written information about their rights under state law to make health care decisions, including the right to accept or refuse treatment and the right to exclude advance directives.

Blue Cross NC recognizes the difficulty of making decisions about the health care of a loved one. The decision to administer treatment of extraordinary means is an issue with no easy answers, an issue which will elicit a variety of responses from different people. Thinking about these issues is difficult; however, a member may wish to set out in advance what sort of treatment he or she would like to receive under serious physical or behavioral health conditions. It may be that a member will become seriously ill or injured and unable to make these decisions for themselves.

Considering and discussing his/her views on life sustaining treatment when they are not under pressure or strain may make the process somewhat less difficult. The member may then wish to draft an advance directive, which instructs his/her physician regarding the types of treatment they want or do not want under special, serious medical conditions. Alternatively, they may wish to designate health care power of attorney to an individual who will make health care decisions should they become unable to do so.

The Blue Medicare HMO and Blue Medicare PPO Evidence of Coverage informs members of their right to make health care decisions and to execute advance directives. We urge members to become informed about advance directives and then discuss any questions or concerns they have about these directives with their primary care physician. Discussion of advance directives should be noted in the member's medical record. Additionally, Blue Cross NC participating physicians are required to keep a copy of an advance directive a member has written in the member's medical record.

3.2
Special procedures to assess and treat enrollees with complex and serious medical conditions

As a managed care organization with a contract with CMS, Blue Cross NC is required by the Medicare Managed Care Manual (**Chapter 4, Section 110.6** – Ensuring Coordination of Care) to ensure identification of individuals with complex and serious medical conditions, assessment of those conditions, identification of medical procedures to address and/or monitor the conditions and development of plans appropriate to those conditions. To meet this CMS requirement, Blue Cross NC sends out an initial health risk assessment questionnaire to new members at the time of enrollment asking members to complete the questionnaire. Member participation is voluntary.

The members mail the completed survey to Blue Cross NC. The information in the survey is entered into a database. If the sum of the results is equal to or greater than a designated score, the member is flagged as potentially at risk for having or developing a complex physical and/or behavioral health condition. The member receives a letter indicating a care manager will contact him or her for an additional assessment.

Members identified as potentially at risk for having or developing a complex physical and/or behavioral health condition will be further screened/assessed by their PCP and/or care manager to determine if they have a complex physical and/or behavioral health condition.

The PCP must develop a treatment plan including an adequate number of visits to a contracting specialist to accommodate the treatment plan. Based on the results of the detailed assessment, the care manager, in cooperation with the PCP or managing physician identifies and documents problems, provides interventions and coordinates services that support the member's needs and the physician's treatment plan. This function is carried out by Blue Cross NC care management staff or designated vendor.

3.3
Requirements for agreements with contracting and sub-contracting entities

The current provider agreement outlines provisions which must be agreed to in order to provide services to Blue Cross NC members. These provisions include time frames regarding record retention for inspection purposes and other key rules a provider must realize when dealing with a government-sponsored program. Please refer to your contract for details.

3.4
Requirements for provider credentialing and provider rights

Blue Cross NC follows a documented process governing contracting and credentialing. It does not discriminate against any classes of health care professionals, and has policies and procedures which govern the denial, suspension and termination of provider contracts. Providers have the right to: 1. review information submitted to support their credentialing application; 2. correct erroneous information; and 3. receive the status of their credentialing and recredentialing application, upon request. This includes requirements that providers meet Original Medicare requirements for participation, when applicable. Qualified providers must have a Medicare provider number for participation. For more information, refer to **Chapter 19, Credentialing**.

3.5
Defines payments to contractors and sub-contractors as "federal funds," subject to applicable laws

Blue Cross NC payments for Medicare services for Blue Medicare HMO and Blue Medicare PPO members are considered "federal funds." Providers are reminded to meet all laws applicable to entities that accept federal funds. These laws relate to anti-discrimination, rehabilitation act, civil rights, as well as others issues. Please refer to your contract for details.

3.6
Confidentiality and accuracy of medical records or other health and enrollment information (including disclosure to enrollees and other authorized parties)

Providers are reminded that member identifiable data should not be released to entities other than Blue Cross NC or Blue Cross NC authorized representatives without the consent of the member, except as required by law. Further, providers are advised that members have a right to access their own medical records subject to reasonable guidelines developed by providers.

3.7
Risk adjustment data validation program

Risk adjustment payment methodology

The Balanced Budget Act (BBA) of 1997 mandates that CMS payments to Medicare Advantage (MA) organizations are based on the demographics and health status of each beneficiary. This payment methodology uses risk adjustment, which is sometimes called case-mix adjustment, that incorporates diagnoses from hospital inpatient, hospital outpatient and physician services into adjusted capitated payments made to MA organizations.

Since the passage of the BBA, CMS moved from a demographic-based payment system to a risk adjusted payment system. That means that 100% of the MA's capitation for each member will be based on his or her demographics and relative health status as evidenced by hierarchical condition categories (HCC). HCCs are groupings of diagnostic codes that CMS regards as indicative of health status. These codes must be documented within encounter medical records at least once in a benefit year.

Under this payment methodology, ensuring complete and accurate demographic and diagnostic data is collected and reported to CMS is not only required by federal law, it is paramount to Blue Cross NC's ability to receive premiums in a manner that supports stable member premiums and funds to pay providers.

The BBA mandates that MA plans collect and submit beneficiary level CD-10-CM data to CMS. This data is used to determine the health status of each beneficiary. The capitation for each beneficiary is then adjusted to reflect the dollars needed to care for a beneficiary in a subsequent payment period.

Continued ▶

Risk adjustment data validation

Risk adjustment does not require a change in the way claims are filed or reported, although Blue Cross NC has implemented a process to allow providers to send in more than 12 diagnostic codes for an encounter when necessary (see Recommendation to Submit Additional Claim for Chronic and Acute Conditions). MA organizations must attest annually to the completeness and accuracy of the data submitted to CMS for risk adjustment. CMS performs data validation to verify that the diagnosis codes submitted by the MA organizations are supported by the medical record documentation for a member. Data discrepancies may affect a risk-adjusted payment. The data validation process begins with the beneficiary records supplied by the physician to the MA organization. It is incumbent on physicians and their office staff to ensure that the documentation is complete and accurate in response to the validation request by the MA organization.

Blue Cross NC performs analyses on provider submitted data to evaluate the completeness and accuracy of that data on a continuous basis. As a result of the analysis, we request and review beneficiary medical records. Any medical record request made for risk adjusted payment validation is allowed under HIPAA regulations without the need to seek authorization from the member. Blue Cross NC has Certified Professional Coders (CPC) within its risk department available to assist providers with any questions regarding diagnostic coding.

3.8
Health Insurance Portability and Accountability Act (HIPAA) privacy regulation fact sheet

The collection of risk adjustment data and request for medical records to validate payment made to MA organizations does not violate the privacy provisions of HIPAA. Therefore, a patient authorized release of information is not required to submit risk adjustment data or to respond to a medical request from CMS for data validation.

CMS requires MA providers to retain medical records of their patients for 10 years plus the current contract year. This requirement includes all contracted physicians, non-physician practitioners, suppliers and facilities submitting claims to Medicare contractors. These medical records must be accurately written, promptly completed, accessible, properly filed and retained. The medical record needs to be in its original form or in a legally reproduced form, which may be electronic, so that medical records may be reviewed and audited by authorized entities. Providers must have a medical record system that ensures that the record may be accessed and retrieved promptly.

Continued ▶

Specific sections of the HIPAA privacy regulation are referenced below:

General reference:

45 Code of Federal Regulations (CFR) Part 164, standards for privacy of individually identifiable health information, final rule.

Web addresses:

ecfr.gov

cms.gov/Regulations-and-Guidance/ Guidance/Manuals/index.html?redirect=/ Manuals/

cms.gov/Medicare/Medicare-General-Information/BNI/ HospitalDischargeAppealNotices.html

cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1022.pdf

CFR references:

42 CFR Subpart M, Sections 422.620, 422.622 and 42 CFR 422.504 [d][2][iii].

Medicare Managed Care Manual, **Chapter 13** – Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

3.9
Notification required upon discharge determination

If the Medicare plan denies coverage of the admission, this guidance does not apply. Instead, the plan must deliver the Notice of Denial of Medical Coverage (or Payment) (NDMCP) with appeal rights.

42 CFR 422.620 and 422.622 require hospitals and Medicare plans to inform Medicare enrollees who are hospital inpatients of their right to obtain a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO) review of a discharge decision. These instructions delineate the expectations of the enrollee (or their representative, if applicable), responsibilities of hospitals, responsibilities of Medicare plans and the role of the BFCC-QIO when the enrollee requests an immediate review by a BFCC-QIO of the discharge decision. The term enrollee means either enrollee or representative, when a representative needs to act for an enrollee.

The term "hospital" is defined as any facility providing care at the inpatient hospital level, whether that care is short- or 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. The definition includes critical access hospitals. Swing beds in hospitals are excluded, because they are considered a lower level of care. Religious non-medical health care institutions are also excluded. These rules apply to Medicare managed care enrollees who are hospital inpatients. Hospital outpatients who are receiving Part B services, such as observation stays or in the emergency department, do not receive these notices unless they are subsequently admitted as an inpatient. Medicare enrollees in hospital swing beds or custodial care beds do not receive these notices when they are receiving services at a lower level of care.

Discharge is defined as a formal release of an enrollee from an inpatient hospital. This includes when the enrollee is physically discharged from the hospital, as well as when the enrollee is discharged "on paper," meaning that the enrollee remains in the hospital, but at a lower level of care (for example, the enrollee is moved to a swing bed or to custodial care).

Section 1866 (a)(1)(M) Delivery of Important Message from Medicare, applies to each individual who is entitled to benefits under Medicare Part A. No matter where in the sequence of payers Medicare falls, these requirements still apply.

Continued ▶

Enrollees who are being transferred from one inpatient hospital setting to another inpatient setting do not need to be provided with the follow-up copy of the notice prior to leaving the original hospital since this is considered the same level of care. Enrollees always have the right to refuse care and may contact the BFCC-QIO if they have a quality of care issue. The receiving hospital must deliver the Important Message from Medicare again.

When a Medicare enrollee is admitted for hospital services that are never covered by Medicare, these notice requirements do not apply.

Instead, Blue Cross NC Blue Medicare will deliver the NDMCP letter guiding the enrollee through the standard or expedited appeals process.

Blue Cross NC contracting hospitals are responsible for issuing the Important Message from Medicare About Your Rights (IM) for the plan. The IM is a statutorily required notice to explain the enrollee's rights as a hospital inpatient, including discharge appeal rights. The time and delivery requirements that apply to Original Medicare enrollee's receipt of this notice and the "follow-up" copy apply for plan enrollees as well.

The notices are available at *cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices*.

A member who is a hospital inpatient has a right to request an immediate review by the BFCC-QIO when Blue Cross NC and the hospital (acting directly or through its utilization review committee), with physician concurrence, determines that inpatient care is no longer necessary. An enrollee who chooses to exercise the right to an immediate review must submit a request to the BFCC-QIO that has an agreement with the hospital where the enrollee is an inpatient. In order to be considered timely, the request must be made no later than midnight of the day of discharge and may be in writing or by telephone. The enrollee should be available to discuss the case upon request by the BFCC-QIO. The enrollee may, but is not required to, submit written evidence to be considered by the BFCC-QIO.

When the enrollee requests a review no later than midnight of the day of discharge, the enrollee is not financially responsible for inpatient hospital services (except applicable coinsurance and deductibles) furnished before noon of the day after the date the enrollee receives notification of the BFCC-QIO decision. Liability for further inpatient hospital services depends on the BFCC-QIO decision.

Continued ▶

Unfavorable determinations

If the BFCC-QIO notifies the enrollee that the BFCC-QIO did not agree with the enrollee, liability for continued services begins at noon of the day after the BFCC-QIO notifies the enrollee that the BFCC-QIO agreed with the hospital's discharge determination, or as otherwise determined by the BFCC-QIO.

Favorable determinations

If the BFCC-QIO notifies the enrollee that the BFCC-QIO agreed with the enrollee, the enrollee is not financially responsible for continued care (other than applicable coinsurance and deductibles) until the Medicare health plan and hospital once again determine that the enrollee no longer requires inpatient care, secures the concurrence of the physician responsible for the enrollee's care, and the hospital notifies the enrollee with a follow-up copy of the IM.

When the enrollee fails to make a timely request for an immediate review and remains in the hospital, he or she may request an expedited reconsideration by Blue Cross NC Blue Medicare as described in Section 422.584, but the enrollee may be held responsible for charges incurred after the day of discharge or as otherwise stated by the plan. If the enrollee receives a favorable reconsideration, the Medicare health plan must continue covering the care and/or refund the enrollee for any expenses the enrollee incurred, minus applicable coinsurance and deductibles.

When the BFCC-QIO notifies Blue Cross NC Blue Medicare that an enrollee has requested an immediate review, Blue Cross NC will coordinate with the hospital to deliver a Detailed Notice of Discharge (the Detailed Notice) to the enrollee as soon as possible but no later than noon of the day after the BFCC-QIO's notification. The plan will consult with the hospital to ensure the language in the Detailed Notice adequately explains to the enrollee why the services are no longer reasonable and medically necessary or are otherwise no longer covered. The hospital will deliver the notice to the patient or their representative. Blue Cross NC Blue Medicare is responsible for ensuring proper execution and delivery of the Detailed Notice.

Upon notification by the BFCC-QIO of the enrollee's request for an immediate review, Blue Cross NC and the hospital are required to submit all information that the BFCC-QIO needs to make its determination, including copies of the IM and the Detailed Notice, as soon as possible, but no later than noon of the day after the BFCC-QIO notifies the hospital of the enrollee's request.

Blue Cross NC is financially responsible for coverage of services during the BFCC-QIO review as provided for in the rules.

3.10
Fast Track appeals process – enrollee rights / provider responsibilities

Enrollees of MA plans have the right to an expedited review by the BFCC-QIO when they disagree with their MA plan's decision that Medicare coverage of their services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) should end. This right is similar to the longstanding right of a Medicare beneficiary to request a BFCC-QIO review of a discharge from an inpatient hospital.

Regulations

SNFs, HHAs and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees. If the enrollee does not agree that covered services should end, the enrollee may request an expedited review of the case by the BFCC-QIO, and the enrollee's MA plan must furnish a detailed notice explaining why services are no longer necessary or covered. KEPRO is the BFCC-QIO for the state of North Carolina.

Continued ▶

The review process generally will be completed within less than forty-eight (48) hours of the enrollee's request for a review. The SNF, HHA and CORF notification and appeal requirements distribute responsibilities among four (4) parties:

1. The MA organization generally is responsible for determining the discharge date and providing, upon request, a detailed explanation of termination of services. (In some cases, MA organizations may choose to delegate these responsibilities to their contracting providers.) Blue Cross NC policy requires the provider to issue the Notice of Medicare Noncoverage (NOMNC) within the required timeline when services are scheduled to terminate or when the plan determines a discharge date.
2. The provider is responsible for delivering the NOMNC to all enrollees no later than two (2) days before their covered services end.
3. The patient/MA enrollee (or authorized representative) is responsible for acknowledging receipt of the NOMNC and contacting the BFCC-QIO (within the specified timelines) if they wish to obtain an expedited review.
4. The BFCC-QIO is responsible for immediately contacting the MA organization and the provider if an enrollee requests an expedited review and making a decision on the case by no later than the day Medicare coverage is predicted to end.

The notice and appeal procedures went into effect on January 1, 2004. You should be aware that the Medicare law (Section 1869[b][1][F] of the Social Security Act) established a parallel right to an expedited review for "fee-for-service" Medicare beneficiaries. CMS implemented the procedure July 1, 2005 for these beneficiaries.

For additional information on the Fast Track appeals process review the following website:

- *cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices*

3.11
What do the SNF, HHA and CORF notification requirements mean for providers?

Notice of Medicare Non-Coverage (NOMNC)

The NOMNC is a short, straightforward notice that simply informs the patient of the date that coverage of services is going to end and describes what should be done if the patient wishes to appeal the decision or needs more information. CMS has developed a single, standardized NOMNC that is designed to make notice delivery as simple and burden-free as possible for the provider.

- The NOMNC essentially includes only four (4) variable fields (i.e., patient name, patient identification number, type of coverage [SNF, HH, CORF or Hospice] and last day of coverage) that the provider will have to fill in.

Plan contact information is added to the last section of the letter in the event that the request for a Fast Track appeal is not met, the provider/member may contact the plan for an appeal through the plan.

Plan contact information

Blue Medicare HMO or Blue Medicare PPO

Attn: Appeals and Grievances Unit
P.O. Box 17509
Winston-Salem, NC 27116-7509

Blue Cross and Blue Shield of North Carolina Blue Medicare HMO or Blue Medicare PPO Toll Free:

1-888-310-4110 for HMO members
1-877-494-7647 for PPO members
TTY/TDD: **711**
Fax: **1-336-794-1556** or **1-888-375-8836**
Attention: Appeals and Grievances Unit

When to deliver the NOMNC

Based on the MA organization's determination of when services should end, the provider is responsible for delivering the NOMNC no later than two (2) days before the end of coverage. If services are expected to be fewer than two (2) days, the NOMNC should be delivered upon admission. If there is more than a two (2) day span between services (i.e., in the home health setting), the NOMNC should be issued on the next to last time services are furnished. CMS encourages providers to work with MA organizations so that these notices can be delivered as soon as the service termination date is known. A provider need not agree with the decision that covered services should end, but it still has a responsibility under its Medicare provider agreement to carry out this function.

How to deliver the NOMNC

The provider must carry out "valid delivery" of the NOMNC. This means that the member (or authorized representative) must sign and date the notice to acknowledge receipt. Authorized representatives may be notified by telephone if personal delivery is not immediately available. In this case, the authorized representative must be informed of the contents of the notice, the call must be documented and the notice must be mailed to the representative.

Expedited review process

If the enrollee decides to appeal the end of coverage, he or she must contact the BFCC-QIO by no later than noon of the day before services are to end (as indicated in the NOMNC) to request a review. The BFCC-QIO will inform the MA organization and the provider of the request for a review, and the MA organization is responsible for providing the BFCC-QIO and enrollee with a Detailed Explanation of Non-Coverage (DENC) of why coverage is ending. The MA organization may need to present additional information needed for the BFCC-QIO to make a decision. Providers should cooperate with MA organization requests for assistance in obtaining needed information. Based on the expedited time frames, the BFCC-QIO decision should take place by close of business of the day coverage is to end.

Continued ▶

Importance of timing / need for flexibility

Although the regulations and accompanying CMS instructions do not require action by any of the four (4) responsible parties until two (2) days before the planned termination of covered services, CMS emphasizes that whenever possible, it's in everyone's best interest for an MA organization and its providers to work together to make sure that the advance termination notice is given to enrollees as early as possible. Delivery of the NOMNC by the provider as soon as it knows when the MA organization will terminate coverage will allow the patient more time to determine if they wish to appeal. The sooner a patient contacts the BFCC-QIO to ask for a review, the more time the BFCC-QIO has to decide the case, meaning that a provider or MA organization may have more time to provide required information.

CMS understands the challenges presented by this process and has tried to develop a process that can accommodate the practical realities associated with these appeals. With respect to weekends, for example, many BFCC-QIOs are closed (except for purposes of receiving expedited review requests), as are the administrative offices of MA organizations and providers. Thus, to the extent possible, providers should try to deliver termination notices early enough in the week to minimize the possibility of extended liability for weekend services for either MA enrollees or MA organizations, depending on the BFCC-QIO's decision.

Similarly, SNF providers may want to consider how they can assist patients that wish to be discharged in the evening or on weekends in the event they lose their appeal and do not want to accumulate liability. Tasks such as ensuring that arrangements for follow-up care are in place, scheduling equipment to be delivered (if needed), and writing orders or instructions can be done in advance and, thus, facilitate a faster and more simplified discharge. We strongly encourage providers to structure their notice delivery and discharge patterns to make the process work as smoothly as possible.

3.12
More information

Further information on this process, including the NOMNC and related instructions, can be found on the CMS website at *cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.*

(Also, see regulations at 42 CFR 422.624, 422.626 and 489.27 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance at this same website.)

3.13
Requirements to provide health services in a culturally competent manner

Providers are reminded to provide services in a manner that meets the member's needs. Medicare beneficiaries may have disabilities, language or hearing impairments or other special needs. Blue Cross NC has established TTY/TDD lines and other systems to assist members in getting the benefits to which they are entitled. Please contact our Blue Cross NC Customer Service staff if you are presented with an issue that requires special assistance so that we can assist in connecting the member with community services if such services are not available within the plan.

Additionally, in North Carolina, providers can locate an interpreter to assist in communicating with Spanish speaking patients through the Carolina Association of Translators and Interpreters (CATI). CATI is an association of working translators and interpreters in North Carolina and South Carolina and is a chapter of the American Translators Association. CATI provides contact information for translators and interpreters within North Carolina at *catiweb.org*.

3.14
Member input in provider treatment plan

Members have the right to participate with providers in making decisions about their health care. This includes the choice of receiving no treatment. Blue Cross NC's policy is to require providers to include members and their input in the planning and implementation of their care or, when the member is unable to fully participate in all treatment decisions related to their health care, have an appropriate representative participate in the development of treatment plan for said member, be they parent, guardian, family members or other conservator. This includes educating patients regarding their unique health care needs, sharing the findings of history and physical examinations, and discussing with members the clinical treatment options medically available, the risks associated with treatment options or a recommended course of treatment. Blue Cross NC and providers recognize that the member has the right to choose the final course of action, if any, without regard to plan coverage.

A choice of treatment must not be made without prior consultation with the member as member acceptance and understanding will facilitate successful care outcomes. However, a recommendation by a participating provider for non-covered services does not mean that the services are covered, but as an option may be pursued by the member at the member's expense.

3.15
Termination of providers

In the case of terminations by Blue Cross NC or the provider, Blue Cross NC must notify affected members thirty (30) days before the termination is effective. Thus, we request that providers adhere to termination notice requirements in provider contracts so that members can receive timely notice of network changes.

3.16
Waiver of liability

Original Medicare's waiver of liability provision, which stipulates that the provider must notify the patient if services could be denied as medically unnecessary, does not apply to Blue Cross NC members. Under Original Medicare, if the waiver of liability is signed by the patient, then the patient is liable for charges. With Blue Medicare HMO and Blue Medicare PPO, a waiver of liability is not valid. With the exception of normal copayment/coinsurance amounts, a provider cannot charge a Blue Cross NC member for non-covered services unless the member has received an organization determination from Blue Cross NC denying coverage before the services are rendered. Waivers of liability are not valid and are not effective to make the member liable for the cost of non-covered services.

3.17
Reminder about opt-out provider status

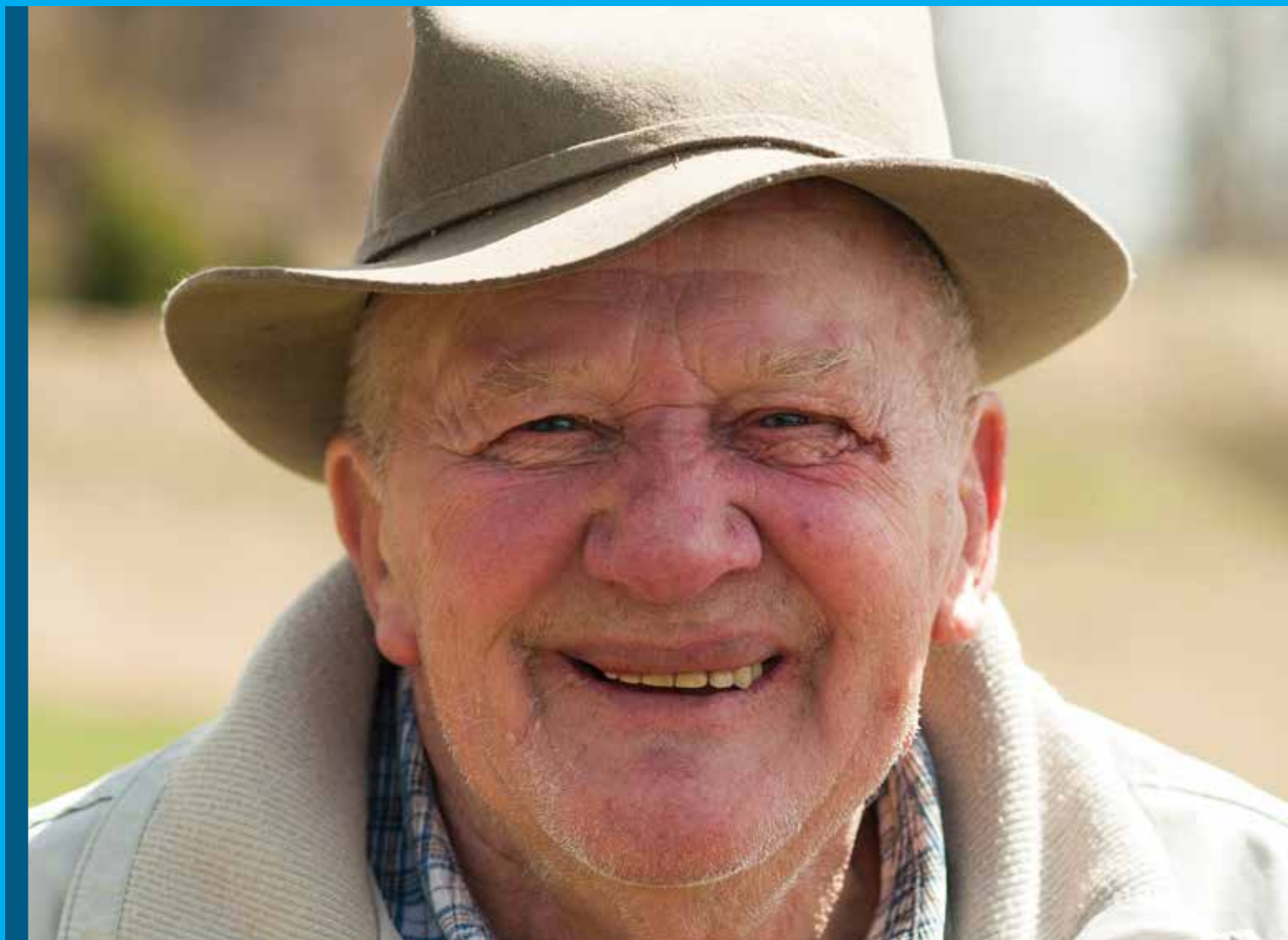
Blue Cross NC cannot use federal funds to pay for services by providers that opt-out of the Original Medicare program and enter into private contracts with Medicare beneficiaries. If you are contemplating this payment approach, please notify Blue Cross NC in advance of sending your termination notice.

3.18
Reminder about excluded and precluded provider status

Blue Cross NC cannot contract with or use federal funds to pay providers that have been excluded or precluded from participation in Medicare. If you are or become excluded or precluded from such participation, please notify Blue Cross NC immediately.

4

Service area, ID cards and provider verification of membership



4.1
Service area for Blue Medicare HMO and Blue Medicare PPO

Blue Medicare Advantage[SM] plans are available to individuals eligible for Medicare Part A and enrolled in Medicare Part B.

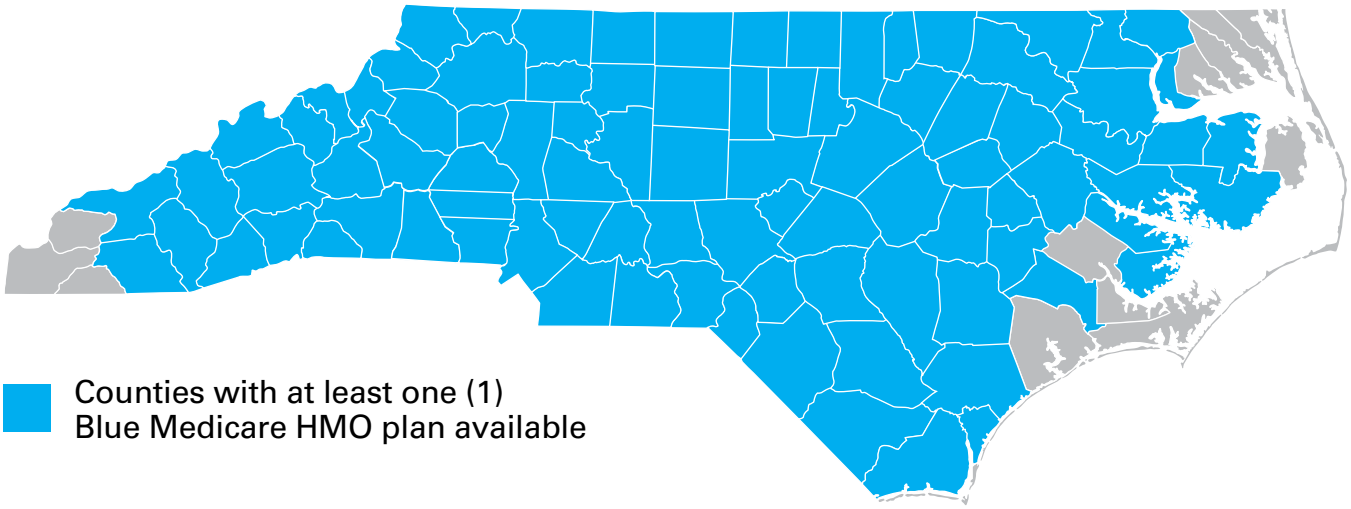
Blue Medicare HMO is a Medicare Advantage plan that includes health care benefits with or without prescription drug coverage in one (1) plan.

Blue Medicare PPO is a preferred provider organization plan that offers health care benefits and prescription drug coverage in one (1) plan.

Blue Medicare HMO and Blue Medicare PPO plans are offered by Blue Cross NC.

Blue Medicare employer group membership can be sold in all one hundred (100) North Carolina counties. Individual plans are available only in select counties across North Carolina within the service area approved by the CMS.

Medicare beneficiaries must live in the following Blue Medicare service areas in order to enroll:

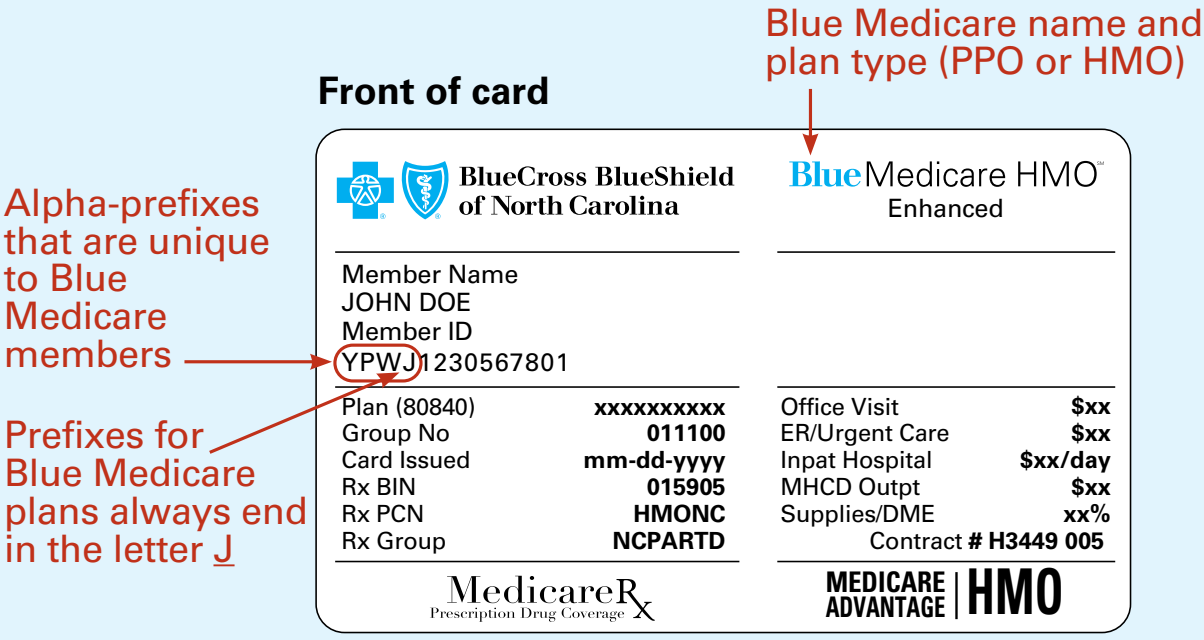


Counties with at least one (1) Blue Medicare HMO plan available

The service area listing is current as of the publication date of this manual. As the service area expands we will provide updates, available on the web at ***BlueCrossNC.com***.

4.2
Blue Medicare identification cards

Blue Medicare HMO and Blue Medicare PPO members have identification cards with a "Blue" look. These cards have the Blue Cross and Blue Shield recognizable symbols. When arranging health care and/or submitting claims for services provided to Blue Medicare HMO and Blue Medicare PPO members, contact Blue Cross NC at our Winston-Salem location instead of our Durham offices. It's easy to distinguish if a claim or question should be directed to Blue Cross NC with a quick look at a Blue Medicare member's identification card. Please see the sample card image below:



One quick glance at the front of the card and you can easily recognize a member as having Blue Medicare, a Blue Cross NC health care coverage plan. The upper right-hand corner of the card displays that it is for a Blue Medicare plan and which plan type a member has enrolled. Look to the card's left and you'll see that a Blue Medicare member's ID includes an alpha-prefix. Blue Medicare alpha-prefixes are unique to Blue Medicare members and always end with the letter **J**.

Continued ▶

The following are unique alpha-prefixes that can help you to identify a Blue Medicare plan type – even when you do not have the member's identification card in hand.

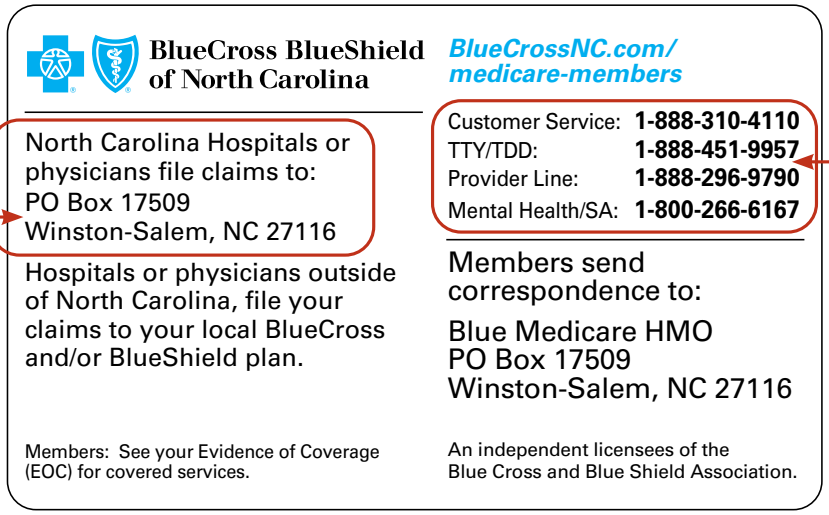
YPWJ – Blue Medicare HMO

YPFJ – Blue Medicare PPO

It's easy to distinguish between Blue Medicare HMO members and Blue Medicare PPO members, just look at the alpha-prefix at the beginning of the member's Blue Medicare identification code. The alpha prefix **YPWJ** lets you know that the member's coverage type is an HMO plan, and if you see **YPFJ**, you'll know that the coverage type is PPO.

The back of a Blue Medicare member's identification card provides further information about arranging health care services and claim submission with Blue Cross NC. The cards display Blue Cross NC claims mailing address and telephone service lines.

Back of card



Blue Cross NC claims mailing address

Blue Cross NC provider service line and Blue Medicare contact information

4.3
Member identification card for Blue Medicare HMO

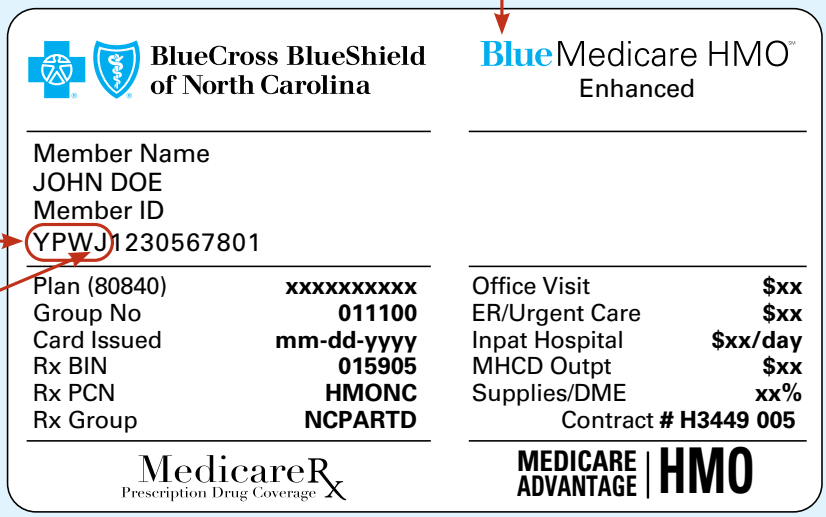
All Blue Medicare HMO members will receive a member ID card when they are enrolled. Patients should be asked to present their Blue Medicare HMO ID card at the time of their visit. You will find it helpful to make a copy of both sides of the member ID card when it is presented by the member. Members should present this card to receive services and not their traditional Medicare card.

Blue Medicare name and plan type (HMO or PPO)

Front of card

Alpha-prefixes that are unique to Blue Medicare members

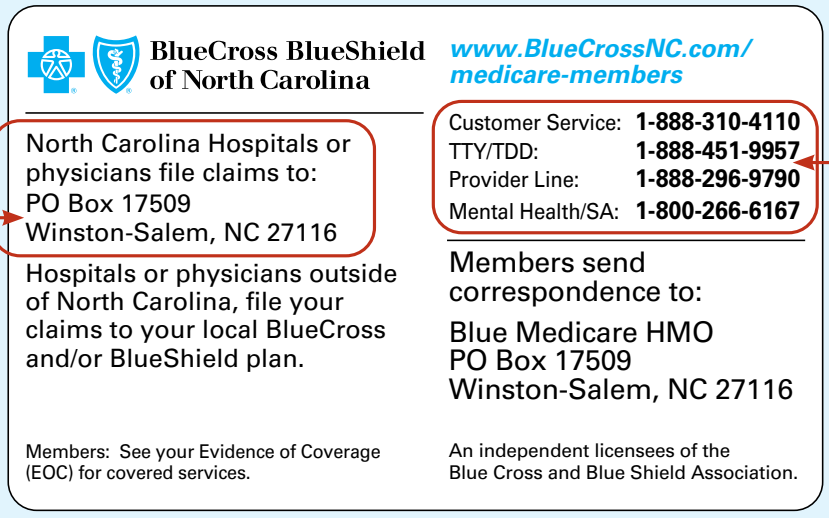
Prefixes for Blue Medicare plans always end in the letter **J**



Back of card

Blue Cross NC claims mailing address

Blue Cross NC provider service line and Blue Medicare contact information



4.4

Member identification card for Blue Medicare PPO

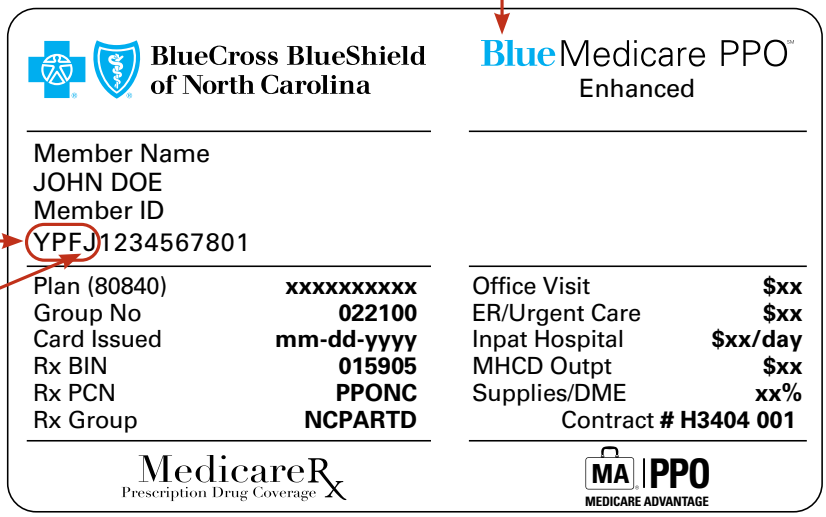
All Blue Medicare PPO members will receive a member ID card when they are enrolled. Patients should be asked to present their Blue Medicare PPO ID card at the time of their visit. You will find it helpful to make a copy of both sides of the member ID card when it is presented by the member. Members should present this card to receive services and not their traditional Medicare card.

Blue Medicare name and plan type (HMO or PPO)

Front of card

Alpha-prefixes that are unique to Blue Medicare members

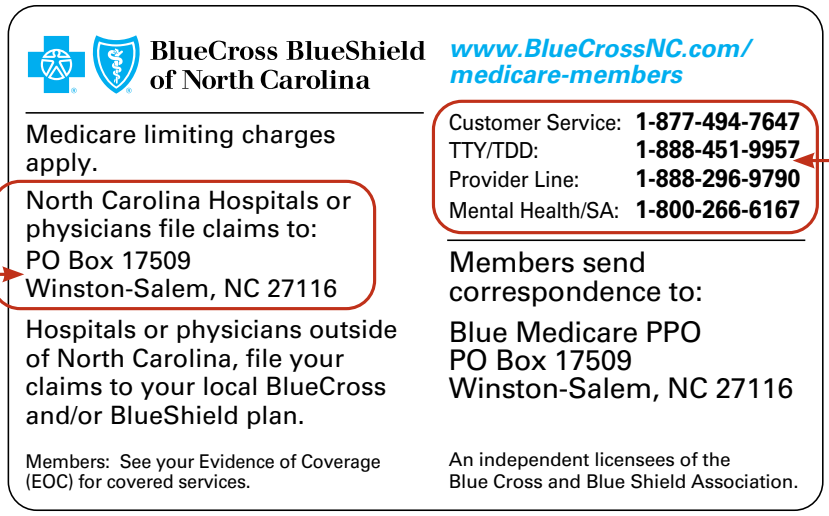
Prefixes for Blue Medicare plans always end in the letter J



Back of card

Blue Cross NC claims mailing address

Blue Cross NC provider service line and Blue Medicare contact information



4.5
Verification of membership

Possession of a Blue Medicare member ID card does not guarantee eligibility for benefits coverage or payment. Providers should verify eligibility with Blue Cross NC in advance of providing services.

Except in an emergency medical condition, providers are required prior to rendering any services to Blue Cross NC members, to request and examine the member's Blue Cross NC Blue Medicare identification card. If a person representing himself or herself as a Blue Medicare member lacks a Blue Medicare HMO or Blue Medicare PPO membership card, the provider should contact Blue Cross NC by telephone for verification before denying such person provider services as a Blue Cross NC member. In an emergency medical condition, the provider will follow these procedures as soon as practical. In the event member is determined to be ineligible for coverage due to retroactive enrollment activity and/or incorrect information submitted to Blue Cross NC by an employer group, Blue Cross NC will not be responsible for payment for services rendered and provider may seek compensation from the member.

Please refer to the formulary at ***medicare.BlueCrossNC.com/medicare/prescription-drug-coverage***.

4.6
Blue Medicare HMO plans

This summary of benefits for Blue Medicare HMO members is not a guarantee of benefits coverage. Always verify member eligibility and benefits prior to providing services.

Blue Medicare HMO provides coverage for:

- Ambulance and urgent care
- Home health care
- Inpatient/outpatient services
- Preventive care
- Skilled nursing facility care
- Worldwide emergency medical care

Blue Medicare HMO is an MA plan that provides members care and services from doctors and hospitals that are within the plan's network. It provides Medicare Parts A and B coverage, while keeping out-of-pocket costs lower.

It also includes:

- Health care benefits and Medicare prescription drug coverage combined in one (1) plan[1,2]
- No referral needed to see a specialist
- Predictable copayments and costs
- Prescriptions filled at participating pharmacies throughout the state, including most of the major chain pharmacies, or through our mail order prescription program
- Additional savings with our Preferred Pharmacy Network
- Additional savings with our Blue365 discount program

Blue Medicare HMO offers different benefit options that share similar features, but there may be differences in amounts paid for things such as copayments and inpatient hospital stays.

1 A formulary applies to all plans that include Medicare prescription drug coverage.
2 Does not apply to Medicare Only plan.
Benefits, premium and/or copayment/coinsurance may change on January 1 of each year. The benefit information provided herein is a brief summary, but not a complete description of available benefits. A member's complete benefits should always be verified in advance of providing service.

4.7
Blue Medicare PPO plans

This summary of benefits for Blue Medicare PPO members is not a guarantee of benefits coverage. Always verify member eligibility and benefits prior to providing services.

Blue Medicare PPO plans provides coverage for:

- Ambulance and urgent care
- Home health care
- Inpatient/outpatient services
- Preventive care
- Skilled nursing facility care
- Worldwide emergency medical care

Blue Medicare PPO is an MA plan where care and services from doctors and hospitals are in the plan's network, but also allows members to see doctors outside the network, usually at a higher cost. It provides Medicare Parts A and B coverage, while keeping out-of-pocket costs lower.

It also includes:

- Health care benefits and Medicare prescription drug coverage combined in one (1) plan[1]
- No referral needed to see a specialist
- Predictable copayments and costs
- Prescriptions filled at participating pharmacies throughout the state, including most of the major chain pharmacies, or through our mail order prescription program
- Additional savings with our Preferred Pharmacy Network
- Additional savings with our Blue365 discount program

There may be multiple Blue Medicare PPO plans available in certain service areas. While each cover the same benefits, there are differences in the amount paid for out-of-network services, copayments and inpatient hospital stays.

Please Note: Plans are subject to change prior to annual enrollment periods each year.

1 A formulary applies for all plans that include Medicare prescription drug coverage.
Benefits, premium and/or copayment/coinsurance may change on January 1 of each year. The benefit information provided herein is a brief summary, but not a complete description of available benefits. A member's complete benefits should always be verified in advance of providing service.

4.8
Additional benefits for Blue Medicare members

Vision services

Coverage for eye exams and more, plus an allowance for eyewear.

Meals benefit

Post-discharge meal program offers two meals per day for 14 days.

Healthy aging and exercise program

Members can visit a participating fitness center or YMCA that takes part in the program (please check with the local YMCA for their participation status). Members are also eligible to receive Home Fitness Kits and can choose from 34 unique options. Members are eligible to receive up to two (2) kits each benefit year.

Dental services

Dental allowance for preventive care including exams and X-rays.

Over-the-counter products allowance

Members receive a debit card to use toward the purchase of over-the-counter (OTC) health and wellness products. Benefits are available at the beginning of each quarter of the calendar year (January, April, July and October).

Balances do not carry over from quarter to quarter.

Hearing services

Low pricing on hearing aids and $0 copayment on hearing exams.

4.8.1
Blue365

Members save with exclusive member discounts through Blue365. This program offers discounts to Blue Medicare HMO and Blue Medicare PPO on a variety of products and services that can help members live a more healthy and active lifestyle – all at no additional cost – and that may include:

- Gym memberships
- Healthy eating
- LASIK eye surgery
- Medical bracelets
- Vision services
- And more!

4.8.2
PPO travel program

Our Blue Medicare PPO travel program enables Blue Medicare PPO members traveling in certain states and Puerto Rico to use the networks of other participating Blue Cross and/or Blue Shield Medicare Advantage PPO plans. Please see **Section 4.9** for additional information.

4.9
Medicare Advantage PPO network sharing for out-of-state Blue Cross and/or Blue Shield members

Blue Medicare Advantage PPO plans, including the Blue Cross NC offered Blue Medicare PPO plan, participate in reciprocal network sharing. This network sharing allows all Blue Cross and/or Blue Shield MA PPO members from another state to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO plan, as long as the member sees a contracted MA PPO provider.

This means that as a provider participating in the Blue Medicare PPO plan, you can see MA PPO members from out-of-state Blue plans; Blue Cross and/or Blue Shield plans other than Blue Cross NC, and these members are eligible to receive their same in-network level of benefits just like when receiving care from their Blue plan's in-network providers at home.

MA PPO network sharing extends the same access of care to MA PPO out-of-state Blue plan members when receiving care in North Carolina that's available to Blue Medicare PPO members, and claims for services will be reimbursed in accordance with your Blue Medicare PPO negotiated rate with Blue Cross NC.

Providers who are not participating in the Blue Medicare PPO plan are not eligible to see MA PPO out-of-state Blue plan members as "in-network." Non-participating providers will receive the Medicare allowed amount for covered services, except for urgent or emergency care. Urgent or emergency care will be reimbursed at the member's in-network benefit level. All other services will be reimbursed at the member's out-of-network benefit (when out-of-network benefits are available) for non-participating providers.

Providers participating with Blue Cross NC, who are already servicing MA members enrolled in the Blue Medicare PPO plan, are required to provide services to out-of-area Blue plan-eligible MA PPO members seeking care within North Carolina. The same contractual arrangements apply to MA PPO out-of-area Blue plan members as with our local Blue Medicare PPO members.

Exception Note: If your practice is currently full (or becomes full) and is closed to all new MA PPO members, you are not required to provide services for MA PPO out-of-area Blue plan members.

4.9.1

How to recognize members from out-of-state Blue plans participating in MA PPO network sharing

The "MA" in the suitcase logo on a member's identification card tells you that the card belongs to a member who is eligible as part of the MA PPO network sharing program. 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 identification cards.

MA | PPO
MEDICARE ADVANTAGE

Providers are reminded that a person's possession of an identification card is not a guarantee of their enrollment, benefits or eligibility in an MA PPO Blue plan. A member's identification, enrollment, benefits and eligibility should always be verified in advance of providing services except when verification is delayed because of urgent or emergency situations.

Verification is easy!

Verifying benefits and eligibility for MA PPO out-of-state Blue plan members is easy! Just call BlueCard® Eligibility at **1-800-676-BLUE (2583)** and provide the member's alpha prefix information that is located on their Blue plan-issued membership ID card. Blue Medicare PPO providers who also participate with Blue Cross NC have the added convenience to submit electronic eligibility requests for out-of-state Blue plan members using **Blue *e***.

4.9.2
Claims administration for out-of-area MA PPO Blue plan members

Network sharing for MA PPO out-of-state Blue plan members makes claims filing simple. After providing services to eligible members, submit claims to Blue Cross NC.

Submit electronic claims to Blue Cross NC under your current Blue Cross NC billing practices, or enroll for electronic claims filing with Blue Cross NC at our Durham-based claims address. Contact Blue Cross NC to set up electronic billing by first visiting the electronic solutions page of the Blue Cross NC website located at: ***BlueCrossNC.com/providers/esolutions/electronic-solutions/submit-electronic-files***.

If it is necessary for you to file a paper claim form, please send claims for MA PPO out-of-state Blue plan members to Blue Cross NC at:

Blue Cross and Blue Shield of North Carolina
P.O. Box 35
Durham, NC 27702

Important!

Claims for services provided to MA PPO out-of-state Blue plan members should be sent to Blue Cross NC. Medicare should not be billed directly.

Claims payment for services provided to MA PPO out-of-state Blue plan members will be based on your contracted Blue Medicare PPO rate. Once you submit a MA PPO claim to Blue Cross NC, the claim will be forwarded to the member's Blue plan for benefits processing. Blue Cross NC will work with the member's out-of-state Blue plan to determine eligible benefits and then send the payment directly to you.

MA PPO out-of-state Blue plan members who see Blue Medicare PPO participating providers will pay in-network cost sharing (in-network copayments, coinsurance and deductibles). Providers may collect any applicable copayment amounts from the member at the time of service. Additionally, providers may collect from members any deductible and/or coinsurance amounts as reflected on the payment remittance for a processed claim (members may not be balance billed for any additional amounts). If you have questions about a processed MA PPO out-of-area Blue plan member's claim, call Blue Cross NC BlueCard Customer Service for assistance at **1-800-487-5522**.

If you have any questions regarding the MA PPO network sharing program for out-of-area Blue plan members, please contact the provider network.

4.9.3
Medicare Advantage PPO network sharing provider claim appeals

Network provider claim appeals:

If you participate in the Blue Medicare PPO plan offered by Blue Cross NC, you will be able to see Blue plan MA PPO members from out-of-state Blue plans. Claims for services provided to out-of-state Blue plan members will be reimbursed in accordance with your Medicare provider agreement with Blue Cross NC. If a participating provider disagrees with claim processing for services provided to an out-of-state Blue plan member, the provider may submit a network provider claim appeal for one of the following reasons:

- Payer allowance/pricing
- Incorrect payment/coding rules applied
- Benefit determinations made by the home plan

The network provider claim appeal must be submitted in writing within ninety (90) days of claim adjudication and may be mailed to:

Blue Medicare PPO
Attention: IPP Provider Appeals
P.O. Box 17509
Winston-Salem, NC 27116-7509

Eligible network provider appeals concerning out-of-state Blue plan members will be completed by the plan within thirty (30) days of the plan's receipt of all information.

Non-network provider claim appeals:

Providers who do not participate in the Blue Medicare PPO plan offered by Blue Cross NC are not eligible to see Blue MA PPO out-of-state members as "in-network." Such "out-of-network" providers will receive the Medicare-allowed amount for covered services, except for urgent or emergency care.

Urgent or emergency care will be reimbursed at the member's in-network benefit level. All other services will be reimbursed at the member's out-of-network benefit level (when out-of-network benefits are available) for non-participating providers.

If a provider disagrees with claim processing for services provided to an out-of-state Blue plan member, the provider may submit a non-network provider claim appeal for one of the following reasons:

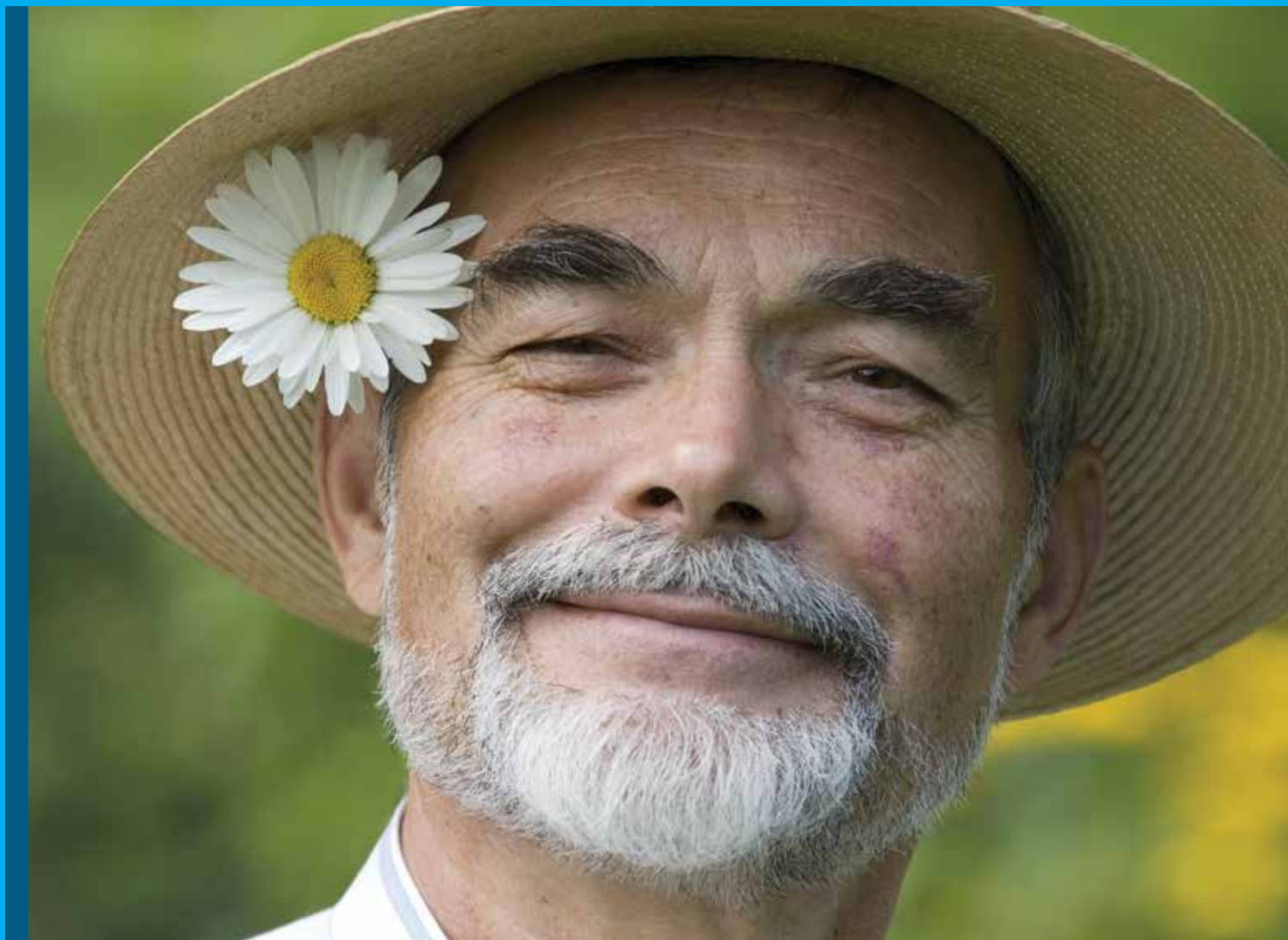
- Medical policy/medical necessity (e.g., cosmetic and investigational)
- Adverse organization determinations made by the home plan

The non-network provider claim appeal may be submitted to the out-of-state member's Blue plan or to the following address:

Blue Medicare PPO
Attention: IPP Provider Appeals
P.O. Box 17509
Winston-Salem, NC 27116-7509

5

Participating physician responsibilities



5.1
Participating physician responsibilities

Blue Cross NC Primary Care Physicians (PCPs) are responsible for providing or arranging for all appropriate medical services for Blue Cross NC members, including preventive care, and the coordination of overall Care Management for the patient. Members enrolled in both the Blue Medicare HMO and Blue Medicare PPO plans may be referred for care outside of their primary care physician's office without a "referral" being written by the primary care physician. However, members enrolled in the Blue Medicare HMO plan do require advanced authorization from Blue Cross NC if being referred to an out-of-network (non-Blue Cross NC HMO) provider or facility. The following specialists may serve as PCPs in certain situations:

- Family practice/general practice doctors provide care for infants, children, adolescents and adults in the areas of community medicine, internal medicine, obstetrics and gynecology, pediatrics, psychiatry and surgery.
- Internists (internal medicine) provide service for treatment of diseases in adults. Normally, they do not deliver babies, treat children or perform surgery.
- Geriatric doctors provide care for older adults.

Blue Cross NC specialists are expected to render high quality care appropriate to the needs of Blue Cross NC members requiring specialized treatment.

5.2
Mental health and substance use

Members do not need a referral to access mental health and substance use services. Members should call Customer Service at **1-888-310-4110**.

5.3
Advanced directives

(Please also refer to **Chapter 3, Administrative policies and procedures**)

Medicare and Medicaid certified hospitals and other health care providers (such as prepaid health plans [HMOs]) must provide all adult members with written information about their rights under state law to make health care decisions, including the right to exclude advance directives. The physician providing care for adult Blue Cross NC members will inquire about each adult member's intention to complete these directive documents and note in the member's medical record whether he/she has executed an advance directive.

5.4
Physician Case Management services

Physician Case Management services include, but are not limited to, team conferences, telephone calls for medical management and/or consultation, prescriptions and prescription refills for Blue Cross NC patients. **Compensation for such services is subject to current Blue Cross NC fee schedules and policies, and allows no compensation for services billed separately by CPT or HCPCS Case Management codes.** Blue Cross NC considers such services part of overall Case Management, and compensation is included in other payments to our providers. Blue Cross NC patients must not be billed directly for Case Management services.

5.5
Physician availability

Blue Cross NC Primary Care Physicians (PCPs)*

Blue Cross NC PCPs are available twenty-four (24) hours a day, seven (7) days a week. If a physician is not available, another Blue Cross NC contracted doctor will be available to provide access to care.

Blue Cross NC OB/GYNs*

Blue Cross NC gives women the advantage of having a PCP plus an OB/GYN. Women may see any Blue Cross NC contracted OB/GYN without a referral from the PCP.

Blue Cross NC vision care specialists*

No referral is required to access participating optometry or ophthalmology providers for vision care.

Blue Cross NC physician specialists*

Specialists servicing Blue Cross NC members are available twenty-four (24) hours a day, seven (7) days a week.

* Please see your Evidence of Coverage for more details, or call Blue Cross NC Customer Service at **1-888-310-4110**, Monday - Friday, 8:00 a.m. until 8:00 p.m. ET. TTY/TDD 711 or **1-888-451-9957**.

6

Quality Improvement program

6.1
Quality Improvement overview[1]

Blue Cross NC believes Quality Improvement (QI) is an imperative component of its managed care product offerings, which include Medicare Part C and D plans, Blue Medicare HMO, Blue Medicare PPO and Blue Medicare Rx.

The Quality Improvement program (QIP) supports Blue Cross NC's ongoing commitment to quality, as stated in our Purpose Statement:

"To improve the health and well-being of our customers and communities – we won't stop until health care is better for all."

Blue Cross NC promotes an environment dedicated to being caring, creative, collaborative and committed. Remaining true to the culture will help us achieve our vision to "be a leader in improving the health care system in North Carolina."

- **Caring** – We distinguish ourselves through superior customer focus and focusing on the larger good of the organization through Enterprise thinking.
- **Collaborative** – We trust our colleagues. We do our best and most important work through teamwork. We know openness to new ideas will help us shape the future of North Carolina's health system.
- **Committed** – We show dedication to do our best work. We take personal accountability by having the courage to identify problems, and the vision to create solutions.
- **Creative** – We know that embracing change is critical to our success. We focus on innovation and problem solving. We share our ideas and seek opportunities for simplification and continuous improvement every day.

Consistent with current professional knowledge, Blue Cross NC defines quality of care for individual populations as the degree to which health services increase the likelihood of desired health outcomes. Quality of service is defined as the ease and consistency with which customers obtain high quality care, as measured by customer perception and objective benchmarks.[1] This includes appropriate access to care.

1 Adapted from the Institute of Medicine.

Continued ▶

In determining the scope and content of its QIP, Blue Cross NC recognizes several concepts related to the delivery of health care, including:

- Quality of care and service is a crucial and integral component of health care delivery
- Existing and potential customers'/groups' unique needs and expectations must be satisfied and exceeded
- Provider relationships with patients and the plan must be continually improved
- Legislative and regulatory requirements must be met and Blue Cross NC must provide leadership for efforts to reform the health care system

The QIP is ongoing and designed to be proactive. It objectively and systematically monitors the quality and appropriateness of the care, service and access provided to members through Blue Cross NC's provider network. The QIP then identifies, implements, monitors and evaluates appropriate interventions to improve the quality of care and service. In other words, the QIP is intended to link the concern for quality and the demonstrated improvement.

The QIP advocates the principles of Continuous Quality Improvement (CQI).

CQI concepts and techniques including the Shewhart Cycle or Plan, Do, Study, Act (PDSA) model; population statistics; and other relevant data sources help focus QI efforts and point to the need for specific projects (Exhibit I). The QIP undergoes constant revision in order to more effectively monitor, evaluate and improve care.

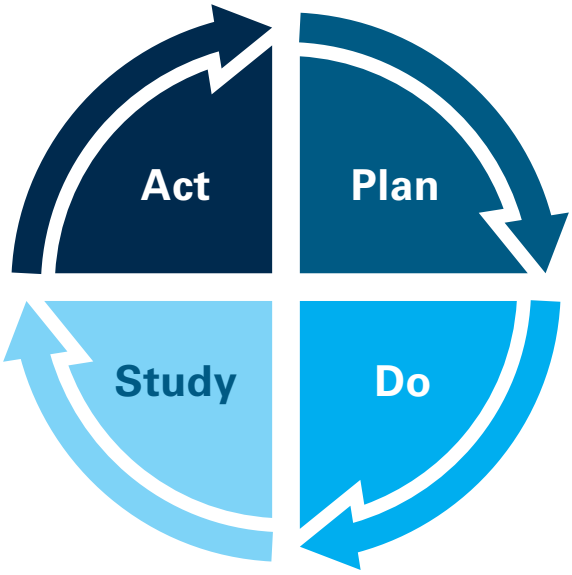


Exhibit I

Continued ▶

The program goals are:

- To support corporate objectives and strategies, including cost-effectiveness and efficiency of care, while continuously improving care outcomes and service delivered to Blue Cross NC members
- To increase the accountability for results of care and service
- To maintain member confidentiality, dignity and safety as they seek and receive care
- To foster a supportive environment to help practitioners and providers improve the safety of their practice
- To utilize evaluative feedback from customers and providers to assess and continually enhance care delivery and outcomes
- To improve clinical effectiveness
- To incorporate QIP results into the selection and recredentialing of network providers and enhance the network providers' ability to deliver appropriate care and meet or exceed the expectations of the patient/member
- To enhance the overall marketability and positioning of Blue Cross NC as the best health care company in North Carolina
- To promote healthy lifestyles and reduce unhealthy behaviors in our members and throughout the communities served
- To provide integrated physical and behavioral health care
- To minimize the administrative costs and burdens incurred by managed care methods
- To maintain and enhance Quality Improvement processes and outcomes that satisfy the requirements of the CMS

Continued ▶

Serve a culturally and linguistically diverse membership by:

- Conducting patient focused interventions with culturally competent outreach materials
- Providing information, training and tools to staff and practitioners to support culturally competent communication

Demonstrate commitment to improving safe clinical practice by:

- Improving continuity and coordination of care between practitioners to avoid miscommunication that can lead to poor outcomes
- Using site-visit results from practitioner and provider credentialing to improve safe practices
- Analyzing and taking action on complaint and satisfaction data that relate to clinical safety
- Implementing pharmaceutical management practices that require safeguards to enhance patient safety

6.2
Access to care standards – primary care physician

Blue Cross NC and the physician advisory group have established the following access to care standards for primary care physicians.

EMERGENT CONCERNS (LIFE THREATENING) SHOULD BE REFERRED DIRECTLY TO 911 OR THE CLOSEST EMERGENCY DEPARTMENT. IT IS NOT NECESSARY TO SEE THE PATIENT IN THE OFFICE FIRST.

1. Waiting Time for Appointment (number of days)	
A. Urgent – not life threatening, but a problem needing care within 48 hours	
Pediatrics	See within 48 hours
Adults	See within 48 hours
B. Symptomatic non-urgent – e.g., cold, no fever	
Pediatrics	Within 30 calendar days
Adults	Within 30 calendar days
C. Follow-up of urgent care	
Pediatrics	Within 7 days
Adults	Within 7 days
D. Chronic care follow-up – e.g., blood pressure checks, diabetes checks	
Pediatrics	Within 14 days
Adults	Within 14 days
E. Complete physical/health insurance	
Pediatrics	Within 30 calendar days
Adults	Within 30 calendar days

Continued ▶

2. Time in Waiting Room (minutes)

A. Scheduled

30 minutes

After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time = 60 minutes.

B. Work-ins/Walk-ins

(Called that day prior to coming)

Pediatrics and Adults – after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time = 90 minutes.

Blue Cross NC discourages walk-ins, but reasonable efforts should be made to accommodate patients. Life threatening emergencies must be managed immediately.

3. After Hours Calls and Coverage

A. Response time returning call after-hours and during lunch

Urgent*	20 minutes
Other	1 hour

B. Coverage

Practice has a recorded telephone message instructing the patient to go to the ER for any life-threatening event or refer them to the physician on-call or to an answering service.

* **Note:** Most answering services cannot differentiate between urgent and non-urgent. Times indicated make assumption that the member notifies the answering service that the call is urgent, and that the physician receives enough information to make a determination.

Continued ▶

4. Language

Interpreter services are available either in the practice, with a contracted interpreter company (TransAtlantic) or through hospital services.

5. Office Hours

Indicates the posted hours during which appropriate personnel are available.

Daytime Hours/Week	7 hours per day x 5 days = 35 hours
Nighttime Hours/Weekend	24 hours/day coverage

6.3
Access to care standards – specialist (including non-MD specialist)

The following access to care standards for specialists have been established by the Blue Cross NC physician advisory group. Non-MD specialists are Chiropractors (DC), Podiatrists (DPM), Physical Therapists (PT), Speech Therapy (ST) and Occupational Therapists (OT).

1. Waiting Time for Appointment (number of days)	
A. Urgent – not life threatening, but a problem needing care within 48 hours	
Pediatrics	See within 48 hours
Adults	See within 48 hours
B. Regular	
Pediatrics	(e.g., tube referral) – Within 2 weeks
Adults	SUB-ACUTE PROBLEM (of short duration) – Within 2 weeks CHRONIC PROBLEM (needs a long time for consultation) – Within 4 weeks

2. Time in Waiting Room (minutes)
A. Scheduled
30 minutes After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time = 60 minutes.
B. Work-ins
(Called that day prior to coming) **Pediatrics and Adults** – after 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time = 90 minutes.

Continued ▶

3. After Hours Calls and Coverage

A. Response time returning call after-hours	
Urgent	20 minutes
Other	1 hour

B. Coverage

Practice has a recorded telephone message instructing the patient to call 911 or go to the ER for any life-threatening event or refer them to the physician on-call or to an answering service.

Daytime Hours/ Week	40 hours/week
Nightime Hours/Weekend	24 hours/day coverage

4. Language

Interpreter services are available either in the practice, with a contracted interpreter phone line or through hospital interpreter services.

5. Office Hours

Indicates hours during which appropriate personnel are available to care for members.

Daytime Hours/Week	15 hours/week minimum covering at least 4 days

6.4
Facility standards

The following standards for the facilities of practices participating in our managed care programs have been adopted by Blue Cross NC and endorsed by the physician advisory group for use in assessing the environment in which health care is provided to our members.

1 The general appearance of the facility provides an inviting, organized and professional demeanor including, but not limited to, the following:

a. The office name is clearly visible from the street.

b. The grounds are well maintained; patient parking is adequate with easy traffic flow.

c. The waiting area(s) are clean with adequate seating for patients and family members.

d. Exam and treatment rooms are clean, have adequate space and provide privacy for patients. Conversations in the office/treatment area should be inaudible in the waiting area.

2 There are clearly marked handicapped parking space(s) and handicapped access to the facility or a documented process for assisting handicapped patients into the building.

3 A smoke-free environment is promoted and provided for patients and family members.

4a A fire extinguisher is clearly visible and is readily available.

4b Fire extinguishers are checked and tagged yearly.

5 Designated toilet and bathing facilities are easily accessible and equipped for the handicapped (i.e., grab bars).

6a There is an evacuation plan posted in a prominent place or exits are clearly marked, visible and unobstructed.

6b There is an emergency lighting source.

7 Halls, storage areas and stairwells are neat and uncluttered.

Continued ▶

8 There are written policies and procedures to effectively preserve patient confidentiality. The policy specifically addresses: 1) how informed consent is obtained for the release of any personal health information currently existing or developed during the course of treatment to any outside entity, i.e., specialists, hospitals, third party payers, state or federal agencies; and 2) how informed consent of release of medical records, including current and previous medical records from other providers which are part of the medical record, is obtained.

   a. All employees including the contract transcriptionists, if applicable, sign a written confidentiality statement.

9 Restricted, biohazard or abusable materials (i.e., drugs, needles, syringes, prescription pads and patient medical records) are secured and accessible only to authorized office/medical personnel. Archived medical records and records of deceased patients should be stored and protected for confidentiality.

   a. Controlled substances are maintained in a locked container/cabinet. A record is maintained of use.

   b. There is a procedure for monitoring expiration dates of all medications in the office (i.e., medications log).

10 Dedicated emergency kit is available which must include sufficient equipment/supplies to support life until patient can be moved to an acute care facility (at minimum: Ambu Bag [adult and pediatric, if applicable] and oxygen).*

   a. At least one (1) staff member is certified in CPR or basic life support.*

   b. Emergency procedures are in place and are reviewed with staff members annually. Review must be documented.*

   c. Emergency supplies include, but are not limited to, emergency medications (aspirin [adults only], oral glucose, epinephrine and Benadryl).*

   d. Emergency supplies are checked routinely for expiration dates. A log is maintained documenting the routine checks.*

Continued ▶

11 There is a written procedure which is in compliance with state regulations for oversight of mid-level practitioners.

12 There is a procedure for ensuring that all licensed personnel have a current, valid license.

13 A written infection control policy/program is maintained by the practice.

14 There is an annual review and staff in-service on infection control.

15 Sterilization procedures and equipment are in place and being followed.

16 The practice has an Automated External Defibrillator (AED) as part of the emergency equipment and maintains a log to check functionality (not scored).

Note: Standards followed by an asterisk (*) are critical elements. Failure to comply with any of these (numbers eleven [11] and twelve [12] inclusively) could result in a shortened credentialing cycle or possible removal from the network. Failure of a critical indicator is taken to the credentialing committee the month of the review.

6.5
Medical record standards for primary care providers and OB/GYN providers

Standard	Supporting Documentation
1. All pages contain patient identification	1. Each page in the medical record must contain the patient's name or ID number.
2. Each record contains biological/personal data	2. Biographical/personal data is noted in the medical record. This includes the patient's address, employer, home and work telephone numbers, date of birth and marital status. This data should be updated periodically.
3. The provider is identified on each entry	3. Each entry in the medical record must contain author identification (signature or initials).
4. All entries are dated	4. Each entry in the medical record must include the date (month, day and year).
5. The record is legible	5. The medical record must be legible to someone other than the writer.
6. There is a completed problem list	6. The flow sheet includes age appropriate preventive health services. **A BLANK PROBLEM LIST OR FLOW SHEET DOES NOT MEET THIS STANDARD.**
7. Allergies and adverse reactions to medications are prominently displayed	7. Medication allergies and adverse reactions are **PROMINENTLY** noted in a **CONSISTENT** place in each medical record. If significant, allergies to food and/or substances may also be included. Absence of allergies must also be noted. Use NKA (no known allergy) or NKDA (no known drug allergy) to signify this. It is best to date all allergy notations and update the information at least yearly.

Continued ▶

Standard	Supporting Documentation
8. The record contains an appropriate past medical history	8. Past medical history (for patients seen 3 or more times) is easily identified and includes serious accidents, operations, illnesses. For children and adolescents (age 18 and younger), past medical history relates to prenatal care, birth, operations and childhood illness. The medical history should be updated periodically.
9. Documentation of smoking habits and alcohol use and substance use is noted in the record	9. The medical record should reflect the use of or abstention from smoking (cigarettes, cigars, pipes and smokeless tobacco), alcohol (beer, wine, liquor) and substance use (prescription, over-the-counter and street drugs) for all patients age 12 and above who have been seen 3 or more times. It is best to include the amount, frequency and type in use notations.
10. The record includes a history and physical exam for presenting complaints	10. The history and physical documents appropriate subjective and objective information for presenting complaints.
11. Lab and other diagnostic studies are ordered as appropriate	11. Lab and other diagnostic studies are ordered as appropriate to presenting complaints, current diagnosis, preventive care and follow-up care for chronic conditions. It is best to note if the patient refuses to have recommended lab or other studies performed.
12. The working diagnoses are consistent with the diagnostic findings	12. The working diagnosis is consistent with the findings from the physical examination and the diagnostic studies.

Continued ▶

Standard	Supporting Documentation
13. Plans of action/treatments are consistent with the diagnosis(es)	13. Treatment plans are consistent with the diagnosis.
14. Each encounter includes a date for a return visit or other follow-up plan	14. Each encounter has a notation in the medical record concerning follow-up care, calls or return visits. The specific time should be noted in days, weeks, months or PRN (as needed).
15. Problems from previous visits are addressed	15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. Appropriate use of consultant services is documented	16. Documentation in the record supports the appropriateness and necessity of consultant services for the presenting symptoms and/or diagnosis.
17. Continuity and coordination of care between primary and specialty physicians or agency is documented	17. If a consult has been requested and approved, there should be a consultation note in the medical record from the provider (including consulting specialist, SNF, home infusion therapy provider, etc.).
18. Consultant summaries, lab and imaging study results reflect review by the primary care physician	18. Consultation, lab and X-ray reports filed in the medical record are initialed by the primary care physician or some other electronic method is used to signify review. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.
19. Care is demonstrated to be medically appropriate	19. Medical record documentation verifies that the patient was not placed at inappropriate risk as a result of a diagnostic or therapeutic process.

Continued ▶

Standard	Supporting Documentation
20. A complete immunization record is included in the chart	20. Pediatric medical records contain a completed immunization record or a notation that "immunizations are up-to-date."
21. Appropriate use of preventive services is documented	21. There is evidence in the medical record that age appropriate preventive screening and services are offered in accordance with the organization's practice guidelines. (Refer to the Medical Policy section of your provider manual.) It is best to note if patient refuses recommended screenings and/or services (3 or more visits every 3 years).
22. Charts are maintained in an organized format	22. There is a record keeping system in place that ensures all charts are maintained in an organized and uniform manner. All information related to the patient is filed in the appropriate place in the chart.
23. There is an adequate tracking method in place to insure retrievability of every medical record	23. Each medical record required for patient visit or requested for review should be readily available.
24. Review of chronic medications, if appropriate, for the presenting symptoms	24. There is documentation in the record, either through the use of a medication sheet or in the progress notes, that medications have been discussed as appropriate.
25. Each record of a Blue Medicare HMO or Blue Medicare PPO member includes information regarding advanced directives	25. The medical record of a Blue Medicare HMO or Blue Medicare PPO member has a documented notation of whether the member has executed an advanced directive.

Continued ▶

Standard	Supporting Documentation
26. The primary care medical record of Blue Medicare HMO or Blue Medicare PPO members includes documentation of the Health Risk Assessment (HRA)	26. The report of the initial Health Risk Assessment (HRA) of Blue Medicare HMO or Blue Medicare PPO members determined to be potentially at a high-risk status should be evident in the medical records. There is documentation of review by the PCP, and the treatment plan incorporates information from the risk assessment.
Documentation of medical record format used in practice	• Paper • EMR – Electronic Medical Record system is a medical record in an electronic format. • EHR – Electronic Health Record is a system that is electronic and has searchable data fields that allow reports to be run. • Name of EHR system and the version being used.

6.6
Clinical practice and preventive care guidelines overview

Clinical practice and preventive care guidelines help clarify care expectations and, when possible, are developed based on evidence of successful practice protocols and treatment patterns. Clinical practice guidelines are intended to be used as a basis to evaluate the care that could be reasonably expected under optimal circumstances. Preventive care guidelines provide screening, testing and service recommendations based upon national standards.

Nationally accepted guidelines

Blue Cross NC endorses the following nationally recognized clinical practice and preventive care guidelines:

Practice Guidelines
Coronary Artery Disease (CAD) **Source:** American Heart Association **Website:** *heart.org*
COPD **Source:** Global Initiative for Chronic Obstructive Lung Disease (GOLD), based on the collaborative recommendations of the World Health Organization and the National Heart, Lung and Blood Institute: *Executive Summary: Global Strategy for the Diagnosis, Management, and Prevention of COPD (Guidelines)* **Website:** *goldcopd.org*
Depression **Source:** American Psychiatric Association **Website:** *psychiatryonline.org/content.aspx?bookid=28&sectionid=1667485*
Diabetes **Source:** American Diabetes Association: *Clinical Practice Recommendations* **Website:** *diabetes.org*

Continued ▶

Practice Guidelines

Heart Failure

Source: ACCF/AHA Guideline for the Management of Heart Failure

Website: *heart.org*

Hypertension

Source: Journal of the American Medical Association – Evidence-Based Guidelines for the Management of High Blood Pressure in Adults; Report from the Eighth Joint National Committee (JNC 8)

Website: *jamanetwork.com/journals/jama/fullarticle/1791497*

Perinatal Care

Source: American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, 7th edition

Website: *sales.acog.org/Guidelines-for-Perinatal-Care-Eighth-Edition-P262.aspx*

Tobacco Counseling

Source: U.S. Preventive Services Task Force

Website: *uspreventiveservicestaskforce.org/Page/Name/recommendations*

Continued ▶

Preventive health guidelines

Preventive health guidelines are standards of care developed to encourage the appropriate provision of preventive services to patients, according to their age, gender and risk-status. These services include screenings, immunizations and physical examinations.

Preventive Health Guidelines

Initial Medical Evaluation of Adults

Sources: U.S. Preventive Services Task Force; American Academy of Family Physicians

Website: *uspreventiveservicestaskforce.org*

Website: *aafp.org/online/en/home/clinical/exam.html*

Periodic health assessment for newborns/infants to 24 months

Source: U.S. Preventive Services Task Force

Website: *uspreventiveservicestaskforce.org*

Periodic health assessment for children and adolescents, 2-19 years old

Source: U.S. Preventive Services Task Force; American Academy of Family Physicians

Website: *uspreventiveservicestaskforce.org*

Website: *aafp.org/online/en/home/clinical/exam.html*

Periodic health assessment for adults, 20-64 years old

Source: United States Preventive Services Task Force (USPSTF), Guide to Clinical Preventive Services; American Academy of Family Physicians, Summary of Recommendations for Clinical Preventive Services

Website: *uspreventiveservicestaskforce.org*

Website: *aafp.org/online/en/home/clinical/exam.html*

Continued ▶

Preventive Health Guidelines

Periodic health assessment for adults, 65 years and older

Sources: United States Preventive Services Task Force (USPSTF), Guide to Clinical Preventive Services; American Academy of Family Physicians, Summary of Recommendations for Clinical Preventive Services

Website: *uspreventiveservicestaskforce.org*

Website: *aafp.org/online/en/home/clinical/exam.html*

Routine immunizations

Source: Centers for Disease Control and Prevention

Website: *cdc.gov/vaccines*

Please Note: Guidelines are subject to change. Providers are encouraged to visit the websites for the nationally recognized clinical practice and preventive care guidelines regularly, to receive the most current and up-to-date information available.

7

Emergency care coverage

7.1
Emergency care coverage

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity; including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition, that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in placing the health of an individual or unborn child in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

Emergency services are covered inpatient or outpatient services which are: (1) furnished by a provider qualified to furnish emergency services, and (2) needed to stabilize or evaluate an emergency medical condition.

Coverage is provided worldwide, and prior authorization is not required.

If a member experiences an emergency medical condition, he/she is advised to seek care from the nearest medical facility, call 911 or to seek direction and/or treatment from a physician.

7.2
Urgently needed services

Urgently needed services are covered services that are not emergency services, provided when an enrollee is temporarily absent from the plan's service area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service area but the plan's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required:

1. As a result of an unforeseen illness, injury or condition, and
2. It was not reasonable given the circumstances to obtain the services through plan providers

If such a medical need arises, we request that the member or a representative contact the member's PCP if possible, then seek care from a local doctor or other provider as directed by the PCP. If the member is unable to do the above, he/she may seek care from a hospital emergency room or urgent care center. Prior authorization is not required for urgently needed services.

8

Utilization Management programs

8.1
Affirmative action statement

Blue Cross NC and its associated delegates require practitioners, providers and staff who make Utilization Management-related decisions to make those decisions solely based on appropriateness of care and existence of coverage. Blue Cross NC does not compensate or provide any incentives to any practitioner or other individual conducting Utilization Management review to encourage denials. Blue Cross NC makes it clear to all staff that make Utilization Management decisions that no compensation or incentives are in any way meant to encourage decisions that would result in barriers to care, service or under-utilization of services.

8.2
Pre-authorization review

Requests from providers for coverage of services will be responded to as expeditiously as the member's health requires (Blue Cross NC responds no later than fourteen [14] calendar days). In instances where the member's health or ability to regain maximum function could be jeopardized by waiting up to fourteen (14) calendar days, the provider requesting coverage of services may request an expedited review, in which case the request will be responded to within seventy-two (72) hours. In either case, an extension of up to fourteen (14) calendar days is permitted, if the member requests the extension or if the plan justifies a need for additional information and the extension of time benefits the member. For example, the plan might need additional medical records from non-contracting medical providers that could prevent a denial decision for insufficient clinical information. When the plan takes an extension, the member will be notified of the extension in writing. In either case, the member will be notified in writing of the coverage determination. Pre-authorization decisions for Part B drugs will be made as expeditiously as the member's condition requires, but no later than seventy-two (72) hours after the plan receives the request (or within twenty-four [24] hours for expedited requests). Extensions are not allowed for Part B drug requests.

Continued ▶

In circumstances where there is a question whether or not the plan will cover an item or service, the enrollee, enrollee's representative or the provider on behalf of the enrollee has the right to request a pre-service organization determination (prior authorization) from the plan. Such pre-service requests to the plan (even if to an agent or contractor of the plan, such as a network provider) are requests for an organization determination and must comply with the applicable regulatory requirements. Whenever an enrollee contacts an MA plan to request a service, the request itself indicates that the enrollee believes the MA plan should provide or pay for the service. However, when a provider declines to furnish a service requested by an enrollee, this is not an organization determination because the provider is making a treatment decision (which may be based on the provider's judgment about whether the item or service should be part of the enrollee's treatment plan or whether the provider is willing to furnish the item or service, regardless of coverage by the plan). If the enrollee wishes to request information about coverage of the benefit, the enrollee must contact the MA plan to make a coverage request for the service in question, or the provider may make the coverage request on the enrollee's behalf. The MA plan must educate enrollees and providers that when there is a disagreement with a provider's decision to decline to furnish a service or a course of treatment, in whole or in part, the enrollee has a right to request and receive an organization determination from the MA plan about whether coverage of the benefit would be provided; such determination about coverage would likely address if the item or service is medically necessary. Further, enrollees have the right to seek treatment from other providers (such as from another provider in the network).

8.3
Inpatient review

Blue Cross NC staff perform utilization reviews for emergency admissions and ongoing hospital stays to determine medical necessity, facilitate early discharge planning and to assure timely and efficient health care services are provided. Coverage decisions are made as expeditiously as the member's health condition requires.

8.4
Medical Case Management

Blue Cross NC reviews specific needs of members whose conditions are complex, serious, complicated, chronic or indicative of long-term or high cost medical care, and assists physicians and health care team members to coordinate delivery of high quality services for members in the most effective manner possible. See additional information at ***BlueCrossNC.com/providers/blue-medicare-providers/medical-management-programs-and-services/blue-medicare-case***.

8.5
Ambulatory review

Some services performed or provided in an outpatient setting, such as physician offices, hospital outpatient facilities or freestanding surgical centers require prior authorization. If prior authorization is not required, retrospective review may be conducted to ensure that care provided is necessary and medically indicated.

8.6
Hospital observation

Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate a patient's outpatient condition or determine the need for a possible admission to the hospital as an inpatient.

An admission to observation by the attending physician does not require prior plan approval.

In order to be successful in assuring medically appropriate quality care, we rely on your cooperation. Timely, appropriate reviews require prompt notification of inpatient admissions, the submission of complete medical information or access to patient charts and specification of discharge needs. If after the initial observation period the member's clinical status deteriorates or remains unstable and/or additional clinical information is provided which meets health guidelines for admission, the nurse may authorize an inpatient stay retroactive to the date of the member's admission to the facility as an observation patient. Observation services are defined as care that requires periodic monitoring, either by nursing staff or other staff, in order to evaluate the patient's condition to determine the need for a possible hospital admission. Observation stays are not to exceed 48 hours.

If the member has been discharged at the time the hospital notifies the plan of the inpatient admission, the review of the observation to inpatient level of care will be completed when the claim is processed.

8.7
Medical Oncology services

The Medical Oncology program provides support for our members' cancer care needs. The program helps to reduce the costs associated with managing one of the most complex, expensive and prevalent diseases in the world. Through this program, oncologists and hematologists have online access to decision support tools for selecting cancer treatment regimens that are consistent with current evidence-based guidelines. This program also puts prior authorization safeguards on over fifty (50) expensive therapeutic and supportive drugs. Blue Cross NC initiated its Medical Oncology program for Medicare members in 2017. Additional information about the Medical Oncology program for Blue Medicare HMO and Blue Medicare PPO members is available in this manual located in **Chapter 9**, **Section 9.4** and on the website at ***BlueCrossNC.com/providers/blue-medicare-providers/blue-medicare-prior-plan-approval.***

8.8
Medical Director's responsibility

It is the policy of Blue Cross NC to escalate review of a case to a Medical Director when the assigned review nurse requires additional medical consultation.

This policy is designed to ensure that Medical Directors are involved in the Utilization Management (UM) decision process. Final determinations ensure that medically necessary, safe and cost-effective care is rendered in the most appropriate setting or level of care.

The Medical Director may be able to make a determination based on the information provided; however, in some cases, the Medical Director may request additional clinical information or elect to contact the attending physician to obtain additional information, to discuss an alternative treatment plan or to review the decision with the provider.

8.9
New technology and new application of established technology review

Blue Cross NC reviews new technologies and new applications of established technologies in a timely manner and may approve or deny coverage for use of a new technology or new application of an established technology. "Technologies" may include treatments, supplies, devices, medications and procedures. The review of new technologies and new applications of existing technologies is based on a standardized process which considers formal research, existing protocols, potential risks and benefits, costs, effectiveness and governmental approvals. Blue Cross NC complies with decisions of local carriers based on local coverage determinations and CMS national coverage determinations and guidelines.

8.10
Retrospective review

Retrospective medical necessity review may be conducted when notification is received for services already provided. The review of the retrospective service will be completed when the claim is processed.

Non-certification of service requests

Blue Cross NC may deny coverage for an admission, continued stay or other health care service. Non-certification determinations based on Blue Cross NC requirements for medical necessity, appropriateness, health care setting or level of care or effectiveness are made by the Blue Cross NC Medical Director.

Written notification of general non-certifications are mailed or faxed by Blue Cross NC to the member and provider(s) within the CMS timelines for the case under review. Non-certifications will include reasons for the non-certification, including the clinical rationale, alternative for treatment that Blue Cross NC deems appropriate and instructions for initiating a voluntary appeal or reconsideration of the non-certification. Non-certifications related to continued care in skilled nursing facilities, home health and comprehensive outpatient rehabilitation facility services are distributed by the provider within two (2) days prior to the end of the service authorization or termination of services.

Coverage for services which are subject to the exclusions, conditions and limitations outlined in the member's Evidence of Coverage and consistent with Original Medicare coverage guidelines may be denied by the Blue Cross NC review staff without review by the Blue Cross NC Medical Director.

8.11
Standard data elements

Information required to make Utilization Management decisions and to certify an admission, procedure or treatment, length of stay and frequency and duration of health care may include:

- Clinical information, including primary diagnosis, secondary diagnosis, procedures or treatments, if any
- Pertinent clinical information to support appropriateness and level of service requests, such as history and physical, laboratory findings, progress notes, second opinions and any discharge planning
- Resources, including facility type, name, address and telephone, any surgical assistant information, anesthesia if any, admission date, procedure date and requested length of stay
- Continued stay if any, including date, entity contact, provider contact, additional days or visits requested, reason for extension, diagnosis and treatment plan

Occasionally after making a reasonable effort, the necessary clinical information may not be available or obtainable to make a coverage decision. Coverage decisions will be based on the clinical information available at the time of review. To ensure accuracy of coverage decisions, it is imperative that all required information be provided timely to the plan.

8.12
Disclosure of Utilization Management criteria

Participating providers and covered members may receive copies of the following upon request:

- An explanation of the utilization review criteria and treatment protocol under which treatments are provided
- Written reasons for denial of recommended treatments and an explanation of the clinical review criteria or treatment protocol upon which the denial was based
- The Blue Cross NC formulary and prior authorization requirements for obtaining prescription drugs, whether a particular drug or therapeutic class of drugs is excluded from its formulary and the circumstances under which a non-formulary drug may be covered
- The Blue Cross NC procedures and medically-based criteria for determining whether a specified procedure, test or treatment is experimental

8.13
Care coordination services

Because of the unique health care needs of the Medicare population, health care providers must work as a team to provide and arrange for those necessary health care services. To accomplish this, Blue Cross NC and some of the contracting providers are using a care coordination approach.

Care coordination is personal, individualized and proactive assistance/intervention for providers and members. Continuing interaction between a nurse case manager and a patient under the supervision of the primary care physician can accomplish the following goals:

- Improve access to appropriate care through the availability of a full continuum of health care services including: Preventive care, acute care, primary care, specialty care, long-term care and home health services
- Match and manage patient health care needs to ensure appropriate, effective and efficient delivery of care
- Instruct and reassure the patients and families
- Increase the utilization and benefit of patient education, particularly in the areas of understanding disease processes and therapy, promotion of wellness and health risk reduction
- Coordinate care between different providers
- Avoid duplication of diagnostic tests and procedures

The case manager functions as an advocate for the patient and the patient's family and as a facilitator and extender for the primary care physician. In this role, the care coordinator:

- Conducts health status/risk assessments
- Investigates, reports and assists in resolving complicated social and environmental problems
- Increases compliance with preventive and therapeutic programs
- Facilitates transfer of information between providers and sites of care
- Reviews and follows pharmaceuticals and other therapy to improve compliance and avoid unwanted drug interactions and reactions
- Coordinates social services outside the hospital setting

9

Prior authorization requirements

9.1
Prior authorization guidelines

Prior authorization is a process whereby approval must be obtained from Blue Cross NC before certain services will be covered in accordance with the member's Evidence of Coverage. A PPO member is accountable to ensure prior authorization is requested for certain services if using a non-contracted provider to ensure medical necessity is met. The contracted provider is required to obtain prior authorization for HMO and PPO members.

Services requiring prior authorization by Blue Cross NC depend on whether the member has chosen HMO or PPO coverage.

Cosmetic procedures are excluded in the Evidence of Coverage. Please contact the Care Management department for assistance in determining whether a procedure would be considered cosmetic or medically necessary.

Refer to the Blue Cross NC formulary for medications which may require prior authorization. Refer to the member's Evidence of Coverage for specific coverage of benefits.

To obtain prior authorization, providers can call **1-888-296-9790** to reach Blue Cross NC Care Management.

Services on the Blue Cross NC prior authorization list require the PCP authorized specialist or PPO member to contact the Blue Cross NC Care Management department to obtain an authorization. This list is reviewed periodically and may be changed with appropriate notification to physicians. Prior authorization guidelines are available for review on the website at ***BlueCrossNC.com/provider-home***. You can also contact the provider network to request a current copy.

9.2
Requesting durable medical equipment and home health services

Contracting providers with Blue Cross NC agree to follow Blue Cross NC's prior authorization guidelines when ordering or dispensing durable medical equipment (DME) for Blue Cross NC members. Blue Cross NC's prior authorization guidelines can be found on the Blue Cross NC website at ***BlueCrossNC.com/provider-home***.

Prior authorization is not required for DME that costs less than $1,200 when certain criteria are met. Prior authorization from Blue Cross NC is required for all DME in the following circumstances:

1. DME items which cost more than $1,200.
2. All rental items require prior authorization from Blue Cross NC.
3. Support devices and supplies require prior authorization if the cost exceeds $1,200.
4. Any eligible DME item that is provided as incidental to a physician's office visit.
5. DME provided by a home care provider during a covered home care visit.
6. Equipment and/or supplies used to assure the proper functioning of Blue Cross NC approved DME (equipment or prosthetic).
7. DME provided by a home infusion provider during a covered visit.
8. DME without a valid HCPCS code (not miscellaneous code).

9.2.1
Prior authorizations for DME and home health services

Providers may obtain prior authorization by calling Blue Cross NC Provider Services at **1-888-296-9790**. Please be prepared to provide the relevant clinical information to support the medical necessity of the DME request along with the following required information:

- Patient's name
- Patient's Blue Cross NC ID number
- Type of service or DME requested
- Patient's diagnosis/medical justification in relation to the requested service
- Start and stop date of services
- Ordering physician's name

Participating DME/home health vendors are listed in the online provider directory for information only and should not be directly contacted for services.

DME/home health services requiring arrangement on weekends and after Blue Cross NC business hours may be retrospectively authorized the next business day if medical justification is met and participating vendors are utilized.

9.3
Prosthetics

Contracting providers in Blue Cross NC MA plans agree to follow Blue Cross NC's prior authorization guidelines when ordering or dispensing prosthetics for Blue Cross NC members. Blue Cross NC's prior authorization guidelines can be found on the Blue Cross NC website at ***BlueCrossNC.com/provider-home***.

Coverage will be provided for prostheses and components when it is determined to be medically necessary and when the medical criteria and guidelines are met as outlined in Blue Cross NC's Medicare Part C Medical Coverage Policy. Blue Cross NC's Medical Coverage Policies can be found on the Blue Cross NC website at ***BlueCrossNC.com/provider-home***.

Covered services requiring prior authorization from Blue Cross NC:

- A lower limb prosthetic is covered when the member:
  - Will reach or maintain a defined functional state within a reasonable period of time and;
  - When the member is motivated to ambulate
- An upper limb prosthetic is covered to replace all or part of the function of permanently inoperative or malfunctioning extremity
- Prosthetic substitutions and/or additions of procedures and components are covered in accordance with the functional level assessment when an initial above or below knee prosthetic or a preparatory above knee prosthetic is provided. An explanation of " functional levels" can be found in Local Coverage Determination (LCD) L33787. The LCD may be accessed at *cms.gov/medicare-coverage-database/search/document-id-search-results.aspx?Date=&DocID=L33787&bc=iAAAAAAAAAAAAA%3D%3D&.*
- Stump stockings and harnesses (including replacements) are also covered when these appliances are essential to the effective use of the artificial limb

Non-covered services:

- Coverage will not be approved when the member's functional level is "0." Blue Cross NC's Medical Coverage Policy defines a member's functional level as "0" when the member does not have the ability or potential to ambulate or transfer safely with or without assistance and a prosthetic does not enhance their quality of life or mobility.
- A user-adjustable heel height feature will be denied as not reasonable and necessary
- Routine periodic servicing, such as testing, cleaning and checking of the prosthetic
- Prosthetic donning sleeve
- Repair time used for the following:
  - Evaluating the member
  - Taking measurements
  - Making modifications to a prefabricated item to fit the member
  - Follow-up visits
  - Making adjustments at the time of delivery, or within ninety (90) days after delivery

Providers may obtain prior authorization by calling Blue Cross NC Provider Services at **1-888-296-9790**. Please be prepared to provide the relevant clinical information to support the medical necessity of the prosthetic request.

9.4
Medical Oncology program

AIM Specialty Health (AIM) administers the Medical Oncology program for Blue Cross NC for the management of therapeutic and supportive drugs for members covered under our Blue Medicare HMO and Blue Medicare PPO MA plans. Participating providers arranging and providing therapeutic and supportive drug care for cancer patients are required to comply with the program's prior authorization requirements for the drugs identified in our prior authorization CPT code list when performed in a physician's office, outpatient department of a hospital or in a home setting.

Neither AIM nor Blue Cross NC will issue retroactive certification. However, if the requested authorization is of an urgent nature, the ordering physician can request the certification within forty-eight (48) hours of the procedure.

Please note that unlike the Medical Oncology program for the Blue Cross NC commercial membership, prior authorization is required for all Blue Medicare HMO and Blue Medicare PPO members registered to use **Blue *e***. You will need to register online as Blue Cross NC provides **Blue *e*** to providers free of charge.

If you currently access the AIM ProviderPortal℠[1] to request prior authorization for Blue Cross NC members, you will not need to make any changes or create an additional account. Blue Medicare HMO and Blue Medicare PPO member information became available in the AIM ProviderPortal[1] as of April 1, 2017.

Note: **Blue *e*** is available to access AIM's web-based application, ProviderPortal[1]. However, **Blue *e*** currently cannot be utilized to conduct other electronic transactions for the Blue Medicare HMO and Blue Medicare PPO health care plans.

If you have questions regarding the Medical Oncology program, please contact the provider network for assistance.

Footnote:

1 The AIM ProviderPortal is a web based application that allows providers to perform authorization requests and status updates. The portal requires one single sign-on when logging in through the **Blue *e*** portal. Providers must agree to a HIPPA disclaimer before entering any member information. Failure to comply with these terms may result in immediate termination of access for you and your organization to the AIM ProviderPortal.

The authorized user agrees to the following terms: "Upon submission of this request, I attest the information provided is true, accurate and complete to the best of my knowledge. I understand that the health plan or its designees may perform a routine audit, request the medical documentation to verify the accuracy of the information provided, and take additional action as the health plan or its designee considers appropriate."

9.5
Protocol for potential organ transplant coverage

When a member is considered for any type of transplant, the following information needs to be submitted to Care Management's staff for review:

- Member's name
- Member's Blue Cross NC ID number
- Type of transplant being considered
- All transplants require prior authorization except corneal transplant
- Confirm via facility-provided verification that the facility is a CMS certified facility for the transplant(s)
- Sufficient data to document diagnosis, including a recent complete history and physical examination
- Treatment history
- Procedures/scans used to determine current stage of disease
- Reports of any specialty evaluations
- Copy of reports confirming diagnosis such as bone marrow examinations and/or biopsies

Upon receipt of the information, we will evaluate the records to determine coverage by Blue Cross NC.

10

Pre-admission certification

10.1
Pre-admission certification guidelines

All non-emergency hospital admissions require pre-certification by contacting the Blue Cross NC Care Management department. The following information will be requested:

- Member's name
- Member's Blue Cross NC ID number
- Hospital name
- Admission date
- Admitting physician name
- Admitting diagnosis as well as any supportive or related information (i.e., lab/X-ray results, symptoms, relevant social and medical history, prior treatment and other medical conditions)
- Description of the proposed plan of treatment (i.e., surgery, medical justification for any pre-operative days, lab/radiological testing, medications, need for inpatient care vs. outpatient, admission orders if available and anticipated number of hospitalized days)

If a member is in the hospital longer than the anticipated initial length of stay, the Care Management department will contact you for updates. The information requested will include the following:

- Current medical status
- Current treatment warranting hospitalization
- Anticipated length of stay
- Anticipated discharge plan, including home care or equipment

10.1.1
Non-emergency pre-admission certification

For non-emergency admissions, the participating physician who has admitting privileges at the hospital must follow the process for service determinations as outlined in Section 8.13. For coverage and payment, the hospital agrees that in the event a physician is not designated as a participating physician on the Blue Cross NC roster of participating providers, and the physician seeks to admit a Blue Cross NC member to the hospital, the hospital shall contact Blue Cross NC prior to admission or treatment to verify such physician's status and/or the referral before rendering provider services, unless it is an emergency medical condition. The hospital shall not be entitled to compensation from Blue Cross NC for provider services rendered if the hospital admits a Blue Cross NC member without following the procedures set forth herein or Blue Cross NC determines that the admission was not medically necessary or not in compliance with Blue Cross NC policies, procedures and guidelines.

This does not prevent the hospital from providing services to Blue Cross NC members admitted by non-contracting physicians in non-emergency situations when such admission is not approved by Blue Cross NC.

10.1.2
Emergency admissions

In cases of an emergency admission of a Blue Cross NC member, the hospital is required to notify Blue Cross NC within twenty-four (24) hours of admission of a Blue Cross NC member as an inpatient to the hospital, or by the end of the first business day following the rendering of the emergency care, whichever is later, and to permit review of the admission by a Blue Cross NC representative. The hospital shall not be entitled to compensation from Blue Cross NC for provider services rendered if the hospital fails to notify Blue Cross NC of an admission of a Blue Cross NC member within the time period agreed to above or Blue Cross NC determines that the admission was not a covered service, or not medically necessary and/or not in compliance with the terms of this agreement. The hospital's obligation to notify Blue Cross NC shall be deemed to be satisfied when an employee of the hospital notifies a representative of Blue Cross NC of the admission.

11

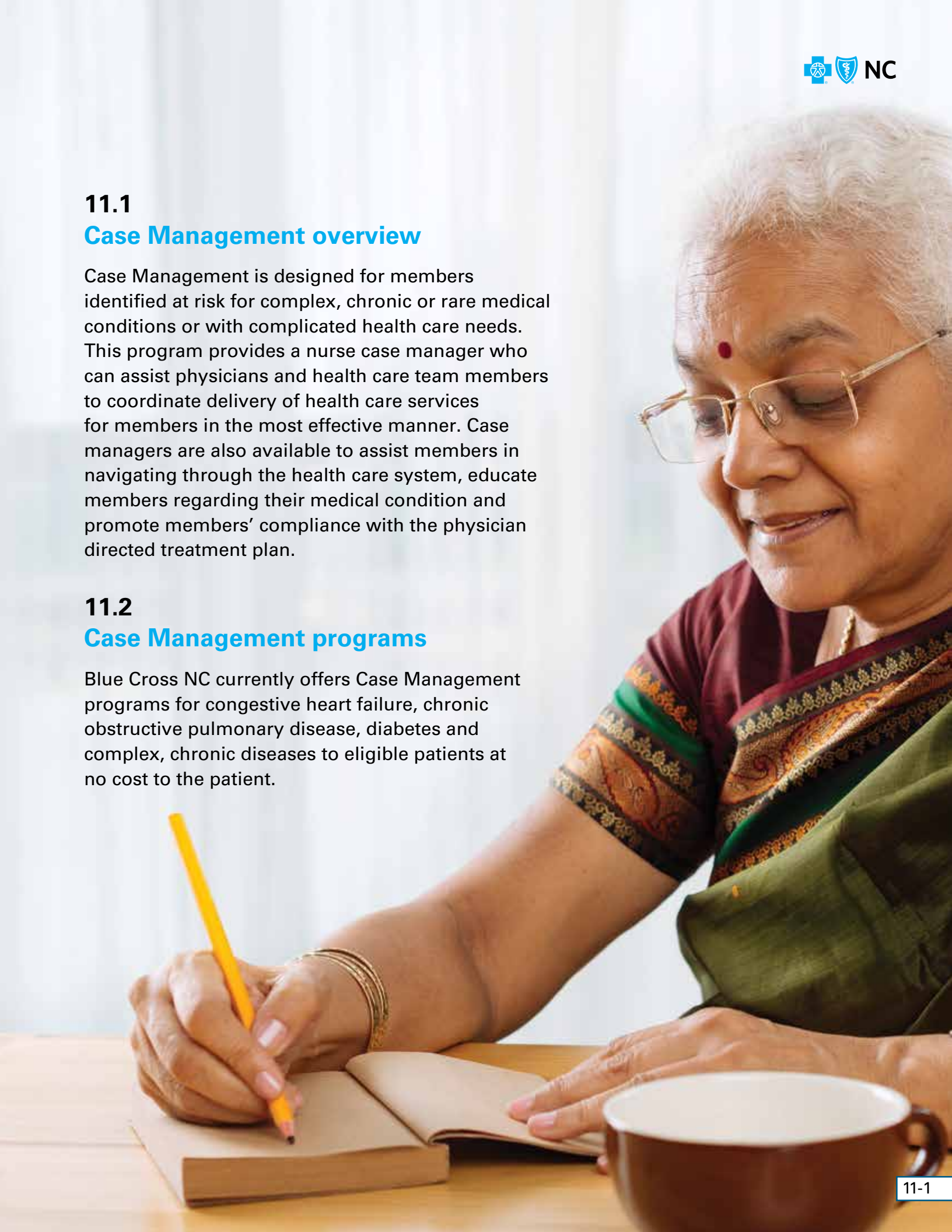
Case Management

11.1
Case Management overview

Case Management is designed for members identified at risk for complex, chronic or rare medical conditions or with complicated health care needs. This program provides a nurse case manager who can assist physicians and health care team members to coordinate delivery of health care services for members in the most effective manner. Case managers are also available to assist members in navigating through the health care system, educate members regarding their medical condition and promote members' compliance with the physician directed treatment plan.

11.2
Case Management programs

Blue Cross NC currently offers Case Management programs for congestive heart failure, chronic obstructive pulmonary disease, diabetes and complex, chronic diseases to eligible patients at no cost to the patient.



11.2.1
Congestive Heart Failure (CHF) Case Management programs

To assist with the management of high-risk CHF patients, Blue Cross NC utilizes a telephonic nursing management approach to identify problems early, facilitate interventions and avoid unnecessary hospitalizations. Patients are assessed and managed for patterns occurring with their disease process. Case managers provide education from MCG's to help them manage the outcomes. Case managers collaborate with the patients' managing physicians to promote effective quality care.

Patients will be considered for participation in the telephonic Case Management program when the disease case manager confirms the patient is high risk or has one (1) or more of the following:

- The level of symptoms associated with heart failure that creates a severe functional limitation for the patient
- A lack of knowledge for self-management is identified through assessment
- A history of relatively rapid deterioration in clinical status when heart failure symptoms appear
- Social isolation or other psychosocial barriers to compliance that places the patient at increased risk for complications. This includes inability to obtain medications and/or follow diet and recommended treatment plan.
- Presence of co-morbidities that are contributing to the severity of symptoms and control of heart failure clinical status such as COPD, diabetes and symptomatic CAD
- Physician referral for the program supported by the CHF diagnosis
- If the member has had a recent inpatient admission with a CHF diagnosis or multiple emergency room visits

11.2.2
Chronic Obstructive Pulmonary Disease (COPD) Case Management programs

To assist with the management of high-risk COPD patients, Blue Cross NC utilizes a telephonic nursing management approach to identify problems early, facilitate interventions and avoid unnecessary hospitalizations. Patients are assessed and may be eligible for a telephonic Case Management program. Case managers collaborate with the patients' managing physicians to promote effective quality care.

Patients will be considered for participation in the telephonic Case Management program when the case manager confirms the patient is high risk or has one (1) or more of the following:

- The level of symptoms associated with COPD creates a severe functional limitation for the patient
- A lack of knowledge for self-management is identified through assessment
- A history of relatively rapid deterioration in clinical status when COPD symptoms appear
- Social isolation or other psychosocial barriers to compliance that places the patient at increased risk for complications. This includes inability to obtain medications and/or follow diet and recommended treatment plan.
- Presence of co-morbidities that are contributing to the severity of symptoms and control of chronic obstructive pulmonary disease clinical status such as CHF, diabetes and symptomatic CAD
- Physician referral for the program supported by the COPD diagnosis
- The member has had an inpatient stay in a hospital for a COPD diagnosis or multiple emergency room visits

11.2.3
Diabetes Case Management programs

To assist with the management of high-risk diabetes patients, Blue Cross NC utilizes a telephonic nursing management approach to identify problems early, facilitate interventions and avoid unnecessary hospitalizations. Patient contact frequencies may change based on individual needs to better accommodate the patient's health status, and/or in collaboration with the patient's physician to promote effective quality care.

Patients will be considered for participation in the diabetes program when the case manager confirms the patient is high risk or has one (1) or more of the following:

- The level of symptoms associated with diabetes creates a severe functional limitation for the patient
- A lack of knowledge for self-management is identified through assessment
- A history of relatively rapid deterioration in clinical status when diabetes symptoms appear
- Social isolation or other psychosocial barriers to compliance that places the patient at increased risk for complications. This includes inability to obtain medications and/or follow diet and recommended treatment plan.
- Presence of co-morbidities that are contributing to the severity of symptoms and control of diabetes clinical status such as COPD, congestive heart failure, hypertension, obesity, dyslipidemia, CVD or neuropathy
- Physician referral for the program supported by the diabetes diagnosis
- Recommendation by the disease case manager involved in the initial and ongoing assessment of the patient to participate in the program
- Diabetes with concomitant cardiovascular disease

11.2.4
Complex / chronic case home-based program

To assist with the management of high-risk, complex members with multiple chronic conditions, Blue Cross NC has collaborated with Landmark Medical of North Carolina (Landmark) to bring home-based medical care to eligible members.

Member qualifying criteria:

- Blue Cross NC Medicare Advantage health plan
- Current health state, complex health needs, and chronic condition algorithm
- Most members have six (6) or more of the following conditions:
  - Atrial fibrillation
  - Cancer/cancer with poor prognosis
  - Cerebral vascular disease
  - Chronic kidney disease
  - Coronary heart disease
  - Dementia
  - Depression/behavioral health
  - Diabetes
  - Heart failure
  - Hypertension
  - Peripheral vascular disease
  - Pulmonary disease
  - Severe chronic liver disease

Continued ▶

Key elements of the Landmark program:

- Home-based medical care by advanced practice providers (MDs, NPs or PAs)
- Routine visits, post-acute visits and urgent visits; visit notes sent to the PCP office after each encounter
- 24/7 availability to treat members at home
- Medication reconciliation
- End-of-life planning with advance directive documentation
- Team-based interdisciplinary care to deploy the right specialist at the right time to help members stay well at home: Behavioral health specialist, palliative care specialist, pharmacist, nurse care manager, dietitian and social worker
- Member and caregiver education
- Care coordination

Landmark providers will communicate with PCPs to drive continuity-of-care and to promote established care plans in the members' homes. This highly coordinated, value-based care is designed to keep members healthy in their home longer, with improved independence and reduced avoidable hospital admissions. Members with complex Case Management needs that are not eligible for Landmark can still be eligible for Case Management services.

11.3
Referrals

To refer patients to one (1) of the Case Management programs please call toll free **1-877-672-7647**.

12

Medical guidelines

12.1
Medical guidelines

Medical guidelines detail when certain medical services are considered medically necessary and are based on Original Medicare national coverage determinations (NCDs) and local coverage determinations (LCDs) when available. The guidelines are reviewed and updated in response to changing CMS guidelines for medical coverage or change in scientific literature if applicable.

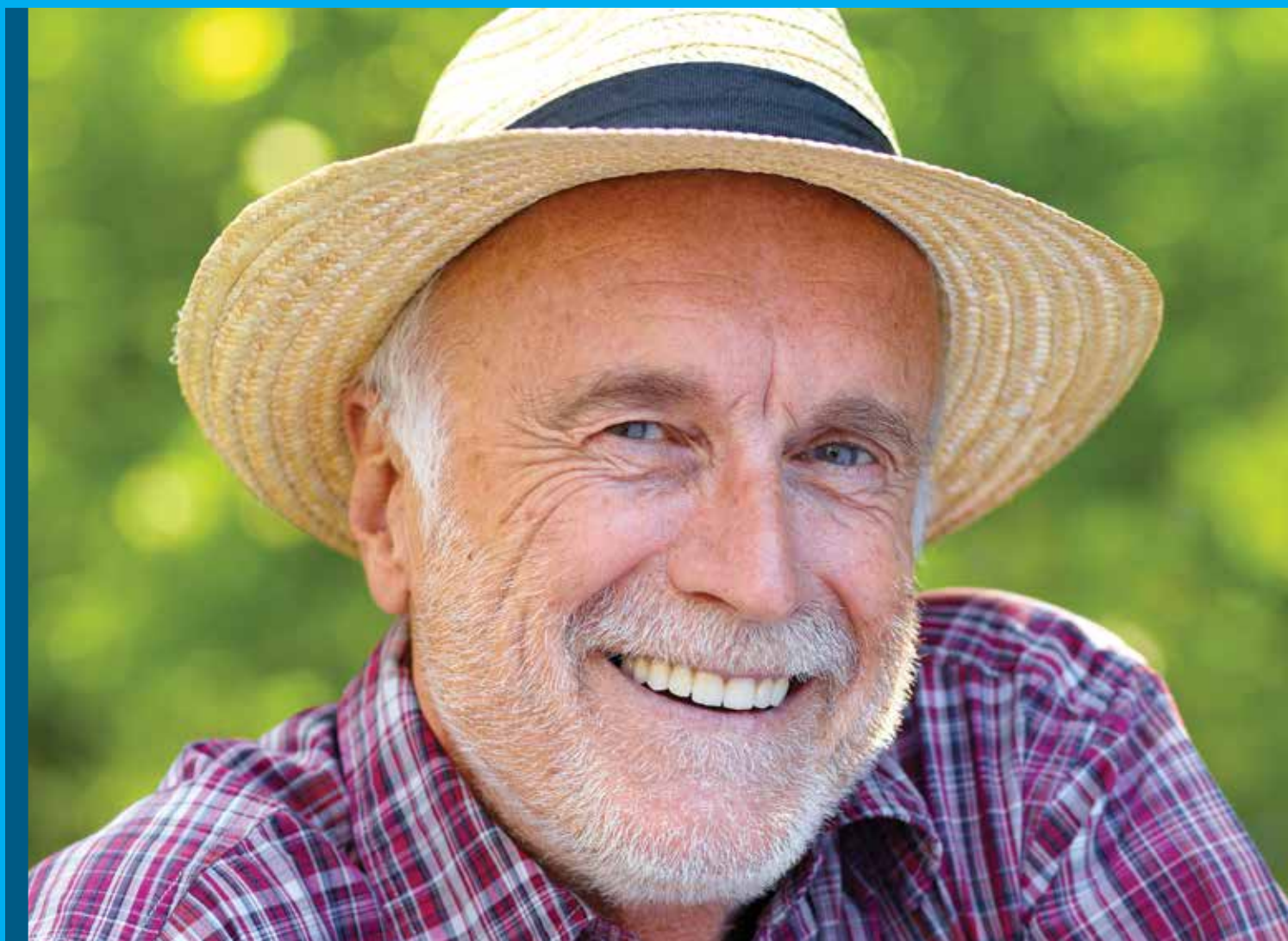
As an MA plan, we are required by CMS to provide, at a minimum, the same medical benefits to our members as Original Medicare. As an MA plan, we cannot be more restrictive than Original Medicare, however, we are allowed to clarify or more fully explain coverage in our policies. If Original Medicare does not have an NCD or LCD applicable to the service under review, the MA plan can develop a guideline to define the plan's coverage. Each individual's unique, clinical circumstances may be considered in light of current CMS guidelines and scientific literature.

Blue Medicare HMO and Blue Medicare PPO medical coverage policies are available for viewing online. Providers can search for a policy to determine the medical necessity criteria needed for a coverage approval. These policies are located on the Blue Medicare HMO and Blue Medicare PPO providers' page of ***BlueCrossNC.com/provider-home***, available at: ***BlueCrossNC.com/providers/blue-medicare-providers/blue-medicare-medical-policy-search***.

Medical policies can be searched by alphabetical listing, as well as a categorical listing to aid you in locating a coverage policy. Questions relative to a specific procedure or pre-certification requirements may be obtained by contacting Care Management at **1-888-296-9790**.

13

Claims billing and reimbursement



Claims billing and reimbursement information contained as part of this supplemental guide is offered in conjunction with the claims billing and reimbursement information contained in The Blue Book, online manual for Blue Cross NC commercial products. In the event that any information stated within this supplemental guide conflicts with information contained within The Blue Book, online manual for Blue Cross NC commercial products, providers should defer to this supplemental guide when submitting claims for Blue Medicare HMO and/or Blue Medicare PPO members.

13.1
General filing requirements

All Blue Medicare HMO and Blue Medicare PPO claims must be filed directly to Blue Cross NC at our Winston-Salem location and not to an intermediary or carrier such as Cigna or Palmetto GBA. Claims must be submitted within one hundred and eighty (180) days of providing a service. Claims submitted after one hundred and eighty (180) days will be denied unless mitigating circumstances can be documented.

Blue Cross NC is committed to processing claims efficiently and promptly. Our imaging system requires that the print on claims submitted be dark and legible to enable accurate scanning. Claims that are complete and accurate are normally processed and paid within seven (7) to fourteen (14) calendar days. A claim that is not complete and accurate may be delayed or returned for revision when the claim is difficult to interpret, incomplete, does not follow usual and customary procedures, does not comply with policies and procedures in this manual, requires manual adjudication or review or is received with a faint image. If filing on paper, please submit optical character recognition (OCR) originals and do not submit carbon copies or photocopies.

The following general claims filing requirements will help ensure that your claims are complete and accurate and will allow us to process and pay your claims faster and more efficiently:

- ***For fastest claims processing, file electronically!*** If you're not already an electronic filer, please visit Blue Medicare HMO and Blue Medicare PPO provider resources for electronic commerce on the web at ***BlueCrossNC.com/providers/blue-medicare-providers/electronic-commerce/*** and find out how you can become an electronic filer.
- Submit all claims within one hundred and eighty (180) days of the date of service
- Do not submit medical records unless they have been requested by Blue Cross NC

- If Blue Cross NC is secondary and you need to submit the primary payor Explanation of Payment (EOP) with your paper claim, do not paste, tape or staple the Explanation of Payment to the claim form. If Blue Cross NC is secondary and you submit the claim electronically, you need to include other insurance allowed amounts, paid amounts, deductible, coinsurance, copay and denied amounts.
- Always verify the patient's eligibility. Prior authorization can be obtained and/or confirmed online by logging onto **Blue *e***, at ***BlueCrossNC.com/providers/esolutions/electronic-solutions***. If you are not currently registered to use **Blue *e***, you will need to register online at ***BlueCrossNC.com***. Blue Cross NC provides **Blue *e*** to providers free of charge.
- Always file claims with the correct member ID number including the alpha prefix **J** and member suffix. This information can be found on the member's ID card.
- File under the member's name as stated on the ID card and not the member's nickname
- Watch for inconsistencies between the diagnosis and procedure code, sex and age of the patient
- Use the appropriate provider/group NPI(s) that matches the NPI(s) that is/are registered with Blue Cross NC, for your health care business
- Blue Cross NC cannot correct claims when incorrect information is submitted. Claims will be mailed back.

Continued ▶

13.1.1
Requirements for professional CMS-1500 (02-12) claim form or other similar forms

(Not to be considered an all inclusive list)

- All professional claims should be filed on a CMS-1500 (02-12) claim form or other similar forms
  - If filing on paper, the red and white printed version should be used
- Once you have registered your NPI with Blue Cross NC, you should include your NPI on each subsequent claim submission to us
  - The tax ID number should correspond to the physician or provider number filed in block 33
- When submitting an accident diagnosis, include the date that the accident occurred in block 14

- Anesthesia claims are to be submitted using anesthesia CPT codes as defined by the American Society of Anesthesiologists. Claims submitted using surgery codes instead of anesthesiology codes will be returned requesting anesthesiology codes.
- File supply charges using the appropriate HCPCS health service codes. If there is no suitable HCPCS code, file unlisted HCPCS code along with a complete description of the supply in the shaded supplemental section of field 24D.
- If you are billing services for consecutive dates (from and to dates), it is critical that the units are accurately reported in block 24G
- To ensure correct payment, include drug name, NDC # and dosage in field 24
  - Please note that the supplemental area of field 24 is for the reporting of NDC codes. Report the NDC qualifier "N4" in supplemental field 24A followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit).

Please note that fields 21 and 24E of the CMS-1500 claim form or other similar forms are designated for diagnosis codes and pointers/reference numbers. Twelve (12) diagnosis codes may be entered into block 21. Any CMS-1500 claim form or other similar forms submitted with more than twelve (12) diagnosis codes or pointers/reference numbers will be mailed back to the submitting provider. If more than twelve (12) diagnosis codes need to be submitted for an encounter, please follow this process (See: Recommendation to Submit Additional Claim for Chronic and Acute Conditions).

- Once a provider has registered their NPI information with Blue Cross NC and Blue Cross NC has confirmed receipt, claims should be reported using the NPI only, and the provider's use of the Blue Cross NC assigned provider and/or group number should be discontinued.

13.1.2
Requirements for institutional UB-04 claim forms

(Not to be considered an all inclusive list)

- All facility claims should be filed on a UB-04 claim form
  - If filing on paper, the red and white printed version should be used
- The primary surgical procedure code must be listed in the principle procedure field locator 74
  - ICD-10 code is required on inpatient claims when a procedure was performed
  - Field locator 74 should not be populated when reporting outpatient services
- Please do not submit a second/duplicate claim without checking claim status first on **Blue *e***
  - Providers should allow thirty (30) days before inquiring on claim status via **Blue *e***
  - Please wait forty-five (45) days before checking claim status through the Blue Cross NC Provider Line

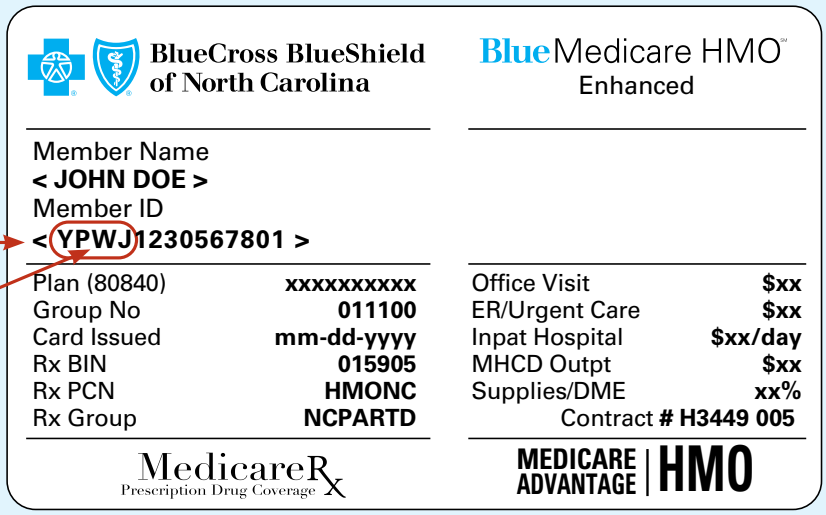
13.2
Using the member's ID for claims submission

When sending claims for services provided to Blue Medicare HMO and Blue Medicare PPO members, it's important that the member's ID be included on the claim form (electronic and paper claims). The alpha-prefix helps North Carolina providers identify what plan type a member has enrolled, but only the last alpha-character of **J** is utilized for claims filing and claims processing. As an example, use the card image for John Doe below:

Front of card - HMO

Alpha-prefixes that are unique to Blue Medicare members

Prefixes for Blue Medicare plans always end in the letter J



- The above sample card displays the member ID for John Doe as: **<YPWJ1230567801>**
- The alpha-prefix of YPW identifies the member's plan type but is not necessary for claims submission (**YPW = HMO** and YPF = PPO)
- The letter **J** is always the last alpha-character of a Blue Medicare HMO or Blue Medicare PPO member's ID. It is used in conjunction with the member's identifying numeric code and is essential for claims routing and processing.
- The numbers **12305678** are part of the member's identifying numeric code – as part of our ongoing efforts to help protect member's privacy, Blue Cross NC assigns member identification codes by use of randomly selected numbers instead of using social security numbers
- The numbers **01** comprise the member's numeric suffix, identifying a specific member

To submit claims for Blue Medicare members, always include the member's alpha-prefix of **J**, the member's numeric code and the member's two (2) digit suffix. As example, **J1230567801** would be reported on a claim submission for member John Doe.

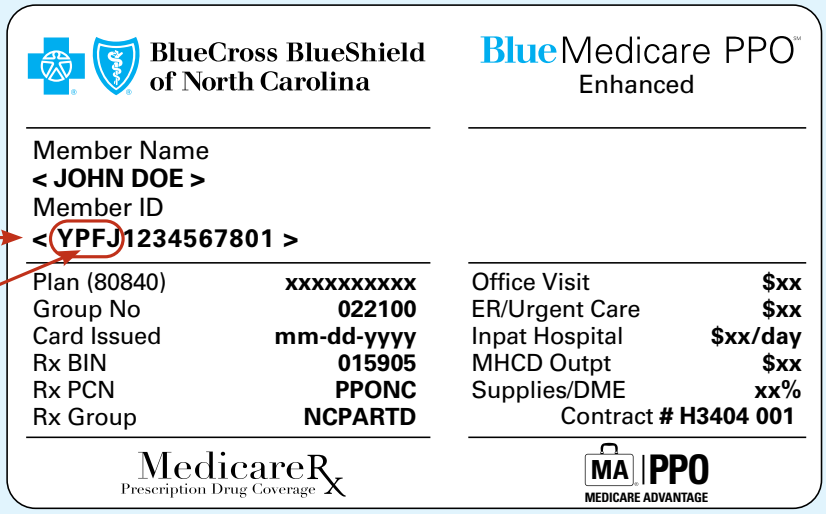
Continued ▶

When sending claims for services provided to Blue Medicare HMO and Blue Medicare PPO members, it's important that the member's ID be included on the claim form (electronic and paper claims). The alpha-prefix helps North Carolina providers identify what plan type a member has enrolled, but only the last alpha-character of **J** is utilized for claims filing and claims processing. As an example, use the card image for John Doe below:

Front of card - PPO

Alpha-prefixes that are unique to Blue Medicare members

Prefixes for Blue Medicare plans always end in the letter J

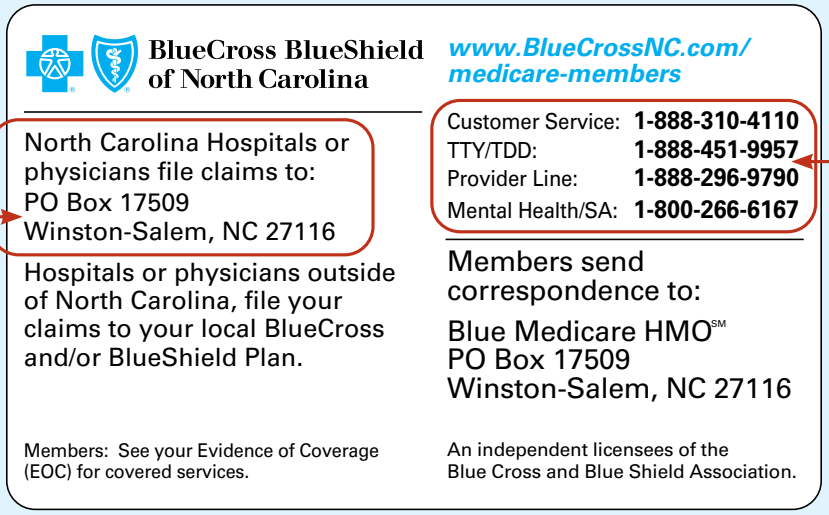


- The above sample card displays the member ID for John Doe as: **<YPFJ1234567801>**
- The alpha-prefix of YPW identifies the member's plan type but is not necessary for claims submission (YPW = HMO and **YPF = PPO**)
- The letter **J** is always the last alpha-character of a Blue Medicare HMO or Blue Medicare PPO member's ID. It is used in conjunction with the member's identifying numeric code and is essential for claims routing and processing.
- The numbers **12345678** are part of the member's identifying numeric code – as part of our ongoing efforts to help protect member's privacy, Blue Cross NC assigns member identification codes by use of randomly selected numbers instead of using social security numbers
- The numbers **01** comprise the member's numeric suffix, identifying a specific member

To submit claims for Blue Medicare members, always include the member's alpha-prefix of **J**, the member's numeric code and the member's two (2) digit suffix. As example, **J1234567801** would be reported on a claim submission for member John Doe.

Continued ▶

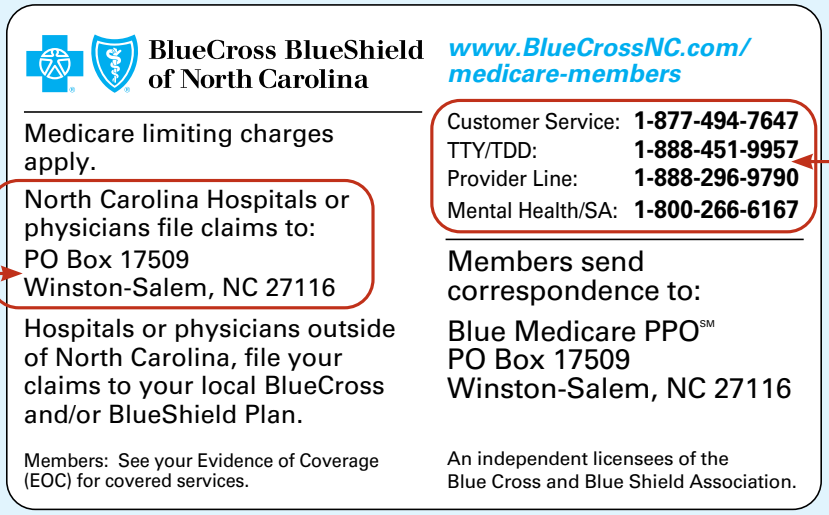
Back of card - HMO



Blue Cross NC claims mailing address

Blue Cross NC provider service line and Blue Medicare contact information

Back of card - PPO



Blue Cross NC claims mailing address

Blue Cross NC provider service line and Blue Medicare contact information

13.3
Electronic claims filing and acknowledgment

The best way to submit claims to Blue Cross NC is electronically. Electronic claims process faster than paper claims and save on administrative expenses for your health care business. For more information about electronic claims filing and other electronic data interchange (EDI) capabilities, please refer to electronic commerce on the web at ***BlueCrossNC.com/providers/esolutions/electronic-solutions***.

EDI Services supports applications for the electronic exchange of health care claims, remittance, enrollment and inquiries and responses. eSolutions also provides support for health care providers and clearinghouses that conduct business electronically. If you are already submitting electronically, and need assistance, contact the eSolutions help desk at **1-888-333-8594**.

Our procedures are designed to have claims which are complete and accurate processed within twenty-four (24) to thirty-six (36) hours upon claims receipt, and provide an EDI acknowledgment report to indicate the status of your claim submission. Please note that payments and Explanation of Payments (EOPs) are based on financial processing schedules. Providers are expected to work their rejected claims report so claims can be resent to Blue Cross NC and accepted for payment.

Requests for service

Health care providers or clearinghouses electing to transmit electronic transactions directly with Blue Cross NC must sign a trading partner agreement and submit the original copy to EDI Services. The trading partner agreement establishes the legal relationship between Blue Cross NC and the trading partner. Health care providers who submit their transmissions indirectly to Blue Cross NC via a clearinghouse do not need to complete the trading partner agreement, but they are required to fill out an electronic connectivity form. The following procedures should be followed to obtain the electronic connectivity form:

- The health care provider can contact the eSolutions help desk at **1-888-333-8594** and make the request to be set up for electronic submission. The health care provider will need to supply a contact name, phone number and email address.
- An email containing an electronic form will then be emailed to the health care provider, which can be filled out electronically. The form will then need to be printed, must be signed and the hard copy returned to Blue Cross NC EDI Services by mail.
- Once the form is received containing all the required information, the health care provider will be set up in the Blue Cross NC system to submit electronically

Continued ▶

- After successful set up, the provider will be mailed a confirmation letter containing their payor ID, user ID, password and instructions for claims filing
- The health care provider must call eSolutions once the confirmation letter is received, and a representative will go over the instructions with the provider and answer any questions at that time. The health care provider should allow eight to ten (8-10) business days to complete the set up process.

Filing requirements:

- Once a transmission is established, all claims (including new claims, additions, corrections and 2nd notices) are to be submitted via EDI
- Coordination of benefits and office notes are to be filed on paper

13.3.1
Sample electronic claims acknowledgment report

Summary Section

				Rejected Status			Accepted	
Submitted BBS ID	Provider ID Number	Total Claims	Total Lines	Map Errors	Load Errors	Denied Claims	Pended Claims	Accepted Claims
A	B	C	D	E	F	G	H	I

A: Submitter identifier
B: Provider's unique identifier as defined by Blue Cross NC
C: Number of claims submitted per provider
D: Number of service lines submitted per provider
E: Number of claims failed in the existence of data check
F: Number of claims failed in the data cross-reference validation
G: Number of claims denied
H: Number of claims pended
I: Number of claims accepted for payments **C = E + F + G + H + I**

Detailed Rejection Section

Original Claim Number	Blue Cross NC Claim Number	Error Type	Error Description
1	2	3	4

1: Invoice number or patient account number as provided by the submitter

2: Blue Medicare claim number

3: Relates to the summary section under rejected status and can be one (1) of three (3) possibilities: Map, load or denied

4: Reason why a claim was rejected

13.4
Blue Medicare claims mailing addresses

Mailing Addresses – Blue Cross NC Blue Medicare HMO and Blue Medicare PPO
Main Mailing Address Blue Cross NC P.O. Box 17509 Winston-Salem, NC 27116-7509
FedEx, UPS and 4th Class Blue Cross NC 5660 University Parkway Winston-Salem, NC 27116-7509

Claims sent in error to Blue Cross NC for Blue Medicare HMO and Blue Medicare PPO members (filed electronically or by mail) will be returned to the submitting provider, which will result in delayed payments.

For Healthy Blue + Medicare claims, do not use these addresses. Please refer to **Chapter/Section 25** for proper filing information.

13.5
Claim filing time limitations

Participating providers agree to complete and submit a claim to Blue Cross NC for services and/or supplies provided to Blue Medicare HMO and/or Blue Medicare PPO members.

The claim should include all information reasonably required by Blue Cross NC to determine benefits according to the member's benefit plan and the provider's typical charge to most patients for the service and/or supplies.

The claim should be submitted only after all complete services have been provided, with the exception of continuous care services or ongoing services.

Claims must be submitted within one hundred and eighty (180) days of providing the service.

Unless qualifying as an eligible exception under guidance of the CMS, corrected claims must be submitted no later than one (1) year (twelve [12] months) from the date of service.

File claims for rental services monthly (after thirty [30] consecutive days of rental), or at the time the rental is determined to no longer be medically necessary, whichever is first.

13.6
Verifying claim status

You can inquire about the status of a claim in one (1) of the following ways:

- Online via **Blue *e***
- By phone:
  - For Medicare Advantage: **1-888-296-9790**
  - For Medicare Supplement: **1-800-672-6584**, option 2 then option 1

Please note that we will be able to research claims and provide better service to you if you wait until after forty-five (45) days from a claim's submission date before initiating an inquiry or resubmitting a previously filed claim. Routinely refiling all claims at the end of the month may cause extra paperwork for everyone involved. We advise all offices to file claims at least once per week, post payments to your accounts within three (3) working days and deposit your checks daily. Also, we would advise you to generate a listing of past due claims at least quarterly. If you need to check on the status on more than five (5) claims at a time, please complete a Provider Inquiry Form.

13.7
Electronic Funds Transfer (EFT)

Blue Cross NC financial services offers EFT for claim payments to participating providers who have registered their bank account information through **Blue *e***. Generally, EFT funds are accessible by providers more quickly than remittances received through a traditional process of paper checks deposited by the provider.

- Providers can view the instructions on how to register for EFT at ***www.bluecrossnc.com/providers/providers-forms-and-documentation*** under "Sign up for electronic funds transfers"
- If the provider is not signed up for **Blue *e***, they can find instructions at ***www.bluecrossnc.com/providers/providers-forms-and-documentation*** under "Signing up for **Blue *e***"
- If the provider still has questions regarding registering for **Blue *e*** or setting up EFT using the instructions provided, please contact the eSolutions help desk at **1-888-333-8594**

13.8
Reimbursement for services

Participating providers agree to bill only Blue Cross NC for all covered services for Blue Cross NC members, collecting only appropriate copayments or coinsurance from the member. Blue Cross NC members are obligated only for the copayment amounts indicated on their member card (and in their Evidence of Coverage or evidence of coverage), payment for non-covered services for which Blue Cross NC issued an organization determination denying coverage before the services are rendered and payment for services after the expiration date of the member's coverage. The provider should not collect any deposits and does not have any other recourse against a Blue Cross NC member for covered or non-covered services.

In the event that the participating provider supplies services which are not covered by the plan, the provider will, prior to the provision of such non-covered services, confirm that the member has received an organization determination from Blue Cross NC denying coverage. Blue Cross NC shall make the relevant terms and conditions of each plan reasonably available to participating providers. If a participating provider is not sure whether a service is covered under a member's Evidence of Coverage, he or she may call the Provider Line at **1-888-296-9790**. The participating providers may only bill a member directly for non-covered services when Blue Cross NC has issued an organization determination informing the member that the services are not covered before the services are rendered (see **Section 13.9.2.1** for information about how to request an organization determination from Blue Cross NC).

13.8.1
Service edits

Blue Cross NC reserves the right to implement service edits to apply correct coding guidelines for CPT, HCPCS and ICD-10 diagnosis and procedure codes. Service edits are in place to enforce and assist in a consistent claim review process. The coding edits reflect Blue Cross NC Medical Coverage Guidelines, benefit plans and/or other Blue Cross NC policies. Unbundling, mutually exclusive procedures, duplicate, obsolete or invalid codes are identified through the use of coding edits.

13.9
Amounts billable to members

- Applicable copayments may be collected at the time service is rendered
- Applicable coinsurance and deductible amounts may be collected at the time the patient is seen. Following are examples of services that may be eligible for the collection of copayment and/or coinsurance:
  - Office visit
  - Office visit with lab and/or X-ray
  - Office-based surgery (when performed in the office and appropriate to be billed in conjunction with an office visit – please refer to current CPT professional edition coding)
  - ER visit
  - Outpatient services
  - Inpatient admission
  - Non-covered services may be collected only if they meet the criteria outlined in the instruction of the hold harmless policy (see **Chapter 13.9.3** for details)
  - Any amounts collected erroneously by you from a member for any reason shall be refunded to the member within forty-five (45) days of the receipt of the notification/explanation of payment from Blue Cross NC or your discovery of the error

13.9.1
Items for which providers cannot bill members

Except for any applicable copayment, coinsurance and/or deductible amounts, providers may not collect any payments from members for covered services or for non-covered services for which Blue Cross NC did not issue an organization determination of non-coverage before the services were rendered.

For covered services, providers may not balance bill Blue Medicare members for the difference between billed charges and the amount allowed by Blue Cross NC, as set forth in the agreement. For non-covered services for which Blue Cross NC did not issue an organization determination denying coverage before the services were rendered, providers may not balance bill Blue Medicare members for the difference between billed charges and any applicable copayment, coinsurance and/or deductible amounts. Any such differences are considered contractual adjustments and are not billable to members or Blue Cross NC.

Providers may not bill or otherwise hold members or Blue Cross NC responsible for payment for services which are deemed by Blue Cross NC to be out of compliance with Blue Cross NC Utilization Management programs and policies, or medical necessity criteria or are otherwise non-covered.

Providers may not seek payment from either members or Blue Cross NC if a proper claim is not submitted to Blue Cross NC within one hundred and eighty (180) days of the date a service is rendered.

13.9.2
Billing members for non-covered services

From time to time, a provider may be asked to provide services to members that are not covered by their benefit plan with Blue Cross NC. A provider can only bill a member for such services when the member has received an organization determination from Blue Cross NC denying coverage before the services are rendered.

A provider cannot use an advanced beneficiary notice or similar type of waiver or release that purports to obligate the member to pay the provider for the non-covered services unless the member has received a pre-service organization determination denying coverage for such service.

Providers may inquire about eligibility of services by calling the Customer Service number on the back of the member's ID card or by calling the Provider Line at **1-888-296-9790**.

Confirmation of benefit eligibility does not guarantee payment as other factors may affect payment (e.g., Blue Cross NC Utilization Management programs and policies or medical necessity criteria).

13.9.2.1
Pre-service organization determination requests

A provider cannot charge a member of a Blue Cross NC MA program (Blue Medicare) for non-covered services (beyond normal cost sharing) unless: (1) the member has received a Notice of Denial of Medical Coverage from Blue Cross NC **before** the services are provided, **and** (2) the member elects to receive the non-covered services after receiving that Notice of Denial of Medical Coverage.

If a provider believes that an item or service may not be covered and the member has not received a Notice of Denial of Medical Coverage from Blue Cross NC, the provider must advise the member to request pre-service organization determination from Blue Cross NC or must request the organization determination on the enrollee's behalf.

The member ***(both HMO and PPO members)*** or the provider may request an organization determination from Blue Cross NC through one of the following:

- Calling **1-888-296-9790**
- Writing to:
  Blue Cross and Blue Shield of North Carolina
  Attention – Part C Organization Determinations
  P.O. Box 17509
  Winston-Salem, NC 27116-7509

  OR
- Faxing a request to **1-336-794-1556**

If a provider supplies non-covered services to a member who has not received a Notice of Denial of Medical Coverage, the provider must hold the member harmless for the non-covered services and cannot charge the member any amount beyond the normal cost sharing.

13.9.3
Hold harmless policy

The member will not be held financially responsible for the cost of covered services except for any applicable copayment, coinsurance or deductible if ALL of the following are true:

- The member has followed the guidelines of the plan
- The PCP or participating specialist fails to obtain pre-certification with Blue Medicare HMO and Blue Medicare PPO health care services department for those covered services which require pre-certification
- The non-pre-certified covered services have already been rendered

The member will not be held financially responsible for the cost of non-covered services except for any applicable copayment, coinsurance or deductible if the non-covered services are rendered before the member receives an organization determination from Blue Cross NC denying coverage.

In either instance, the participating provider will be advised that they must write-off the cost of the non-certified or non-covered services and hold the member financially harmless according to contract provisions.

Ancillary services provided in conjunction with non-pre-certified services are also not payable by the plan unless the ancillary provider is a non-participating provider.

This policy will also apply when the plan is the secondary payer of claims.

Members will be held responsible for non-certified services when the member receives an organization determination from Blue Cross NC denying coverage before the services are rendered.

13.9.3.1
CMS-required provisions regarding the protection of members eligible for both Medicare and Medicaid "dual-eligibles"

Federal legislation implemented changes to the Medicare program. Current network provider agreements in the section entitled "Hold Harmless" incorporate certain CMS-required provisions regarding the protection of members. Changes to CMS's requirements that became effective January 1, 2010, resulted in our obligation to amend our contracts to incorporate specific Hold Harmless provisions as they relate to members that are dually-eligible for both Medicare and Medicaid.

Continued ▶

The section entitled "Hold Harmless" is hereby amended to include the following:

- Members are eligible for Medicaid. Providers agree that members eligible for both Medicare and Medicaid "dual-eligibles" will not be held liable for Medicare Parts A and B cost sharing when the state is responsible for paying such amounts. Provider agrees to accept the MA plan payment as payment in full or bill the appropriate state Medicaid agency for such amounts.

Only qualified Medicare beneficiary (QMB) designated beneficiaries are exempt from copays/coinsurance. Not all dual-eligibles receive assistance with copays/coinsurance. Specified low-income Medicare beneficiaries (SLMB), for example, receive premium assistance only.

13.9.3.2
CMS-required provisions regarding the protection of members who receive non-covered services or supplies from a participating provider

Regulatory guidance issued by CMS resulted in our obligation to amend our contracts to incorporate specific Hold Harmless provisions as they relate to the provision of non-covered services.

Section 2.2, Hold Harmless is hereby amended as follows:

- Provider agrees that except for applicable deductibles, copayments or coinsurance, and except as otherwise required by law, in no event, including but not limited to non-payment, Blue Cross NC insolvency or breach of this agreement, shall provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any direct or indirect recourse for covered services against a Blue Cross NC member, a person acting on such Blue Cross NC member's behalf or a third party including but not limited to subrogation and workers' compensation carriers. Provider agrees that it is the provider's obligation to collect applicable Blue Cross NC member deductibles, copayment and coinsurance, if any, as well as fees for non-covered services. Provider may not collect fees for non-covered services or supplies unless, before services are rendered or supplies are provided, the Blue Cross NC member has received an organization determination from Blue Cross NC informing the member that the specific services to be rendered and/or supplies to be provided are not covered by his or her health benefits plan.

13.10
Coordination of Benefits (COB)

Coordination of Benefits (COB) is an approach used by health plans and health insurers to divide the obligation for payment of health care expenses. It is not uncommon to encounter patients who are covered under more than one (1) health plan. Patients could be receiving coverage from sources that could include a large private insurer, another managed care plan, Medicaid, a self-insured plan or a COBRA-continued plan.

In the event a benefit is covered by both Blue Cross NC and another policy or plan, Blue Cross NC will coordinate benefits and benefit payments with such plans or policies, whether or not a claim is made for benefits.

- If the member is age sixty-five (65) or older and has coverage under an employer group health plan, either through his/her own current employment or the employment of a spouse (including COBRA coverage), that plan will be the primary payer. This rule applies to the health plans of employers with twenty (20) or more employees. Blue Cross NC will be the secondary payer. COBRA policies are an extension of active group coverage. If the member is actively working, group size determines who is primary.
- If the member is under age sixty-five (65) and entitled to Medicare due to a disability (other than end-stage renal disease) and has coverage under a large employer group plan, either through his/her own employment or the employment of a family member, that plan will be the primary payer. Blue Cross NC will be the secondary payer. If the member is actively working, group size determines who is primary.
- If automobile medical or no-fault or liability insurance is available to you, in the event of an accident, that carrier will be the primary payer
- If the member is eligible for Medicare solely on the basis of end-stage renal disease (ESRD) and is covered under an employer group plan, that plan will be the primary payer for the first thirty (30) months after becoming eligible for Medicare
- Workers' compensation for treatment of a work-related illness or injury, or veteran's benefits for treatment of service-connected disability or under the Federal Black Lung Program would be primary payers
- Coverage through Medicaid or through the Tricare for Life program will be coordinated based on Medicare rules

Blue Cross NC uses the same guidelines in these cases as does Medicare. Because of this, we do ask the member about other insurance they may have. If the member has other insurance, they are asked to help us obtain payment from the other insurer by promptly providing any information we may request.

Continued ▶

Blue Cross NC will assist you with information concerning a patient's coverage and will assist you by working directly with patients and their primary insurance sources to ensure that you, the provider, are entitled to the maximum benefit available. Consistent with our contractual obligations, it is also our intent to maximize a member's benefit under our plan. Therefore, if a patient's primary insurance issues a benefits payment that is greater than the Blue Cross NC copayment, the copayment will be waived.

13.11
Workers' compensation claims

If a Blue Medicare member sustains an injury while at work, it is important that the member follow Blue Cross NC's rules and procedures in order to be eligible for Blue Medicare HMO or Blue Medicare PPO benefits, should workers' compensation deny the claim. All applicable authorizations must be obtained under Blue Cross NC guidelines in order for Blue Medicare HMO or Blue Medicare PPO benefits to be payable in the event workers' compensation denies the claim. Failure to follow Blue Cross NC policies will release Blue Cross NC from any payment responsibility.

If you are informed or have reason to believe a patient has sustained an injury at work, please call Blue Cross NC to notify us. We may need to inform other providers so they may also file for benefits under workers' compensation.

For further details on governing rules, or assistance with COB, Medicare or workers' compensation, please contact the Blue Cross NC Customer Service department.

13.12
Subrogation

A Blue Medicare member may incur medical expenses due to injuries suffered in an accident. The accident may have been caused by the alleged negligence or misconduct of another person. If so, the member may have a claim against that person for payment of medical bills.

Subrogation means the right of Blue Cross NC to pursue the claim for medical expenses against the other person, so that the other person (or their insurer) pays for the member's medical expenses.

Blue Cross NC as the medical policy holder is responsible for paying these claims up front, and then our vendor handles the subrogation on those third party claims. We cannot deny claims for workers' compensation, veterans, auto-related or potential subrogation.

Subrogation of benefits is allowed. Therefore, Blue Cross NC has the right to pursue and recover from a claim that may have been filed against another person.

If the member has a claim against another person, Blue Cross NC will be subrogated to the right of recovery the member has against that person. Therefore, Blue Cross NC will deny payment of all medical bills pending settlement of the claim against the other person. If there is not a prompt settlement, Blue Cross NC will conditionally pay the medical bills and require that the member reimburse Blue Cross NC. For this purpose, the definition of prompt will be one hundred and twenty (120) days after the earlier of the following:

- The date a claim is filed with an insurer or a lien is filed against a potential liability settlement; or the date the service was furnished or, in the case of inpatient hospital services, the date of discharge

Blue Cross NC's right of subrogation will not exceed the lesser of the following:

- The amount of benefits paid by Blue Cross NC; or the portion of the recovery attributable to covered medical expenses

If the portion of the recovery that is attributable to medical expenses is not specified in a judgment or settlement, then one-third (1/3) of the net recovery shall be deemed to be the portion of the recovery attributable to medical expenses. Net recovery shall mean the total amount of the recovery less reasonable attorneys' fees and expenses incurred in obtaining the recovery.

13.13
Claims reimbursement disputes

In the event an error is found on an Explanation of Payment (EOP) on behalf of the provider, a request for correction may be initiated either via telephone or in writing. To request a review for correction in writing, the following information must be included:

- Letter of explanation relative to any error in the processing of claim
- Copy of the original claim
- Copy of corresponding EOP with the claim in question circled
- Requests for correction should be mailed to the following address:

  Blue Cross and Blue Shield of North Carolina
  P.O. Box 17509
  Winston-Salem, NC 27116

To request a review for correction via telephone, please contact the Blue Cross NC Provider Line at **1-888-296-9790**, and be prepared to give the following information:

- Patient name and Blue Medicare member ID number
- Date of service
- Claim number
- Explanation of any suspected error

13.14
Pricing policy for Part B procedure / service codes (applicable to all HMO and PPO products)

Effective June 1, 2005, updated 08/23/2010, 09/09/2013 and revised 09/14/2020.

The following policy applies to Blue Cross NC's payment to contracted providers for procedure/service codes billed on a CMS-1500 (Part B Medicare) claim form or other similar forms. When services billed on UB-04 forms are contracted using Fee For Service (FFS) rates, this procedure would also apply.

General pricing policy

When the pricing for an existing code is updated and an external pricing source exists for such code, Blue Cross NC will implement such pricing in accordance with the applicable Blue Cross NC policy. Such updates and new pricing will apply for all dates of services on or after the source pricing effective date, but only for claims received after the date of Blue Cross NC's implementation of the update/new pricing. Blue Cross NC is not required to make retroactive pricing adjustments for claims received prior to Blue Cross NC's implementation date. Updates will be made using the following procedure:

- If NC Medicare pricing is available when an existing code is updated or a new code is added, the most current NC Medicare pricing available will be applied to that code
- If NC Medicare pricing is unavailable, Blue Cross NC will apply the most current Medicare allowable pricing if available, using the same methodology described above and the following external resources:
  - Optum Ingenix
  - Palmetto GBA (*www.palmettogba.com*)
  - Cigna Government Services (*www.cgsmedicare.com*) for DMEPOS
- For durable medical equipment, the Cigna Government Services DME Jurisdiction C fee schedule will be used in place of the above referenced external sources. Source: *www.cignagovernmentservices.com/jc/coverage/fees/index.html.*
- Blue Cross NC reimburses the lesser of your charge or the applicable pricing
- Nothing in this policy will obligate Blue Cross NC to make payment on a claim for a service or supply that is not covered under the terms of the applicable benefit plan. Furthermore, the presence of a code and allowable on your sample fee schedule does not guarantee payment.

Continued ▶

From time to time, either Congress or CMS may modify Medicare fee schedules for a limited duration of time without making commensurate changes to the reimbursement paid to MA organizations. When this occurs, Blue Cross NC reserves the right to forego implementation or application of such changes.

External source pricing

All references in this procedure to external source pricing refer to the following:

- NC Medicare (available at ***www.cms.hhs.gov***)
- Cigna Medicare allowables

In the event that the names of such external source pricing change (e.g., a new Medicare intermediary is selected), references in this procedure will be deemed to refer to the updated names. In the event that new external source pricing generally acceptable in the industry and acceptable to Blue Cross NC becomes available, such external source pricing may be incorporated by Blue Cross NC into this procedure.

13.14.1
Prescription drug CPT and HCPCS codes

These codes are priced following CMS guidelines and do not include those services covered under the CMS Part D program. Codes not falling under a separate prospective payment system will be based on a percentage of average sales price (ASP) or average wholesale price, depending on the drug. Resources used to arrive at rates include websites for CMS and Cigna .

For HIT services, drugs covered by Medicare will be based on the current year DME regional carrier priced Average Wholesale Price (AWP), if infused through DME per Section 303(b) of the Medicare Modernization Act.

Infused drugs not covered by Medicare will be based on the AWP listed in the most recently published and available edition of the *Medicare Economics Red Book Guide to Pharmaceutical Prices* as of the date of service. Blue Cross NC will require the name and dose of the drug provided. Parenteral and enteral nutrition (PEN) will be based on rates contained in the DME POS fee schedule published quarterly by the DME regional carrier (Cigna Government Services at this time).

Drugs not assigned specific HCPCS codes by CMS will be priced using the not otherwise classified (NOC) file as published by the Part B fiscal intermediary (Cigna Medicare at this time).

13.14.2
Policy on payment for remaining codes

Procedure/service codes that remain unpriced after each application of the above procedure will be paid in the interim at the lesser of the provider's charge or a reasonable charge established by Blue Cross NC using a methodology that is applied to comparable providers for similar services. Blue Cross NC's methodology is based on several factors including payment guidelines as published in the Blue Cross NC provider manual. Under these guidelines, some procedures charged separately by the provider may be combined into one procedure for reimbursement purposes.

Blue Cross NC may use clinical judgment to make these determinations and may use medical records to determine the exact services rendered. For codes that Blue Cross NC approves as clinically necessary, have no price applied using any of the procedures described above and billed as less than $100, Blue Cross NC will pay 50% of the provider's billed charge.

13.14.3
Policy on payment based on charges

If a general code (e.g., 21499, unlisted musculoskeletal procedure, head) or unlisted code is filed because a code specific to the service or procedure is non-existent, Blue Cross NC will assign a fee to the service which will be the lesser of the provider's charge or a reasonable charge established by Blue Cross NC using a methodology which is applied to comparable providers for similar services under a similar health benefit plan. Blue Cross NC may use clinical judgment to make these determinations, and may use medical records to determine the exact services rendered.

Durable medical equipment claims or medical or surgical supply claims that are filed under general or unlisted codes must include the applicable manufacturer's invoice and will be paid at the invoice price. Blue Cross NC will not pay more than 100% of the respective charge for these claims.

If a general or unlisted code is filed despite the existence of a code specific to the service or procedure, Blue Cross NC will apply the more specific code to determine payment under Blue Cross NC's applicable reimbursement policies.

Blue Cross NC's assignment of a fee for a given general or unlisted code does not preclude Blue Cross NC from assigning a different fee for subsequent service or procedure under the same code. Fees for these services may need to be changed based on new or additional information that becomes available regarding the service in question or other similar services.

13.15
What is not covered under the medical benefit

This is a list of general exclusions. In some cases, a member's benefit plan may cover some of these services or have additional exclusions. Please call the Blue Cross NC Provider Line at **1-888-296-9790** to verify benefit coverage.

- **Abortion:** Any abortion which is considered illegal under laws which govern the state in which Blue Cross NC is licensed, and any abortion which is not covered by Medicare
- **Allergy testing:** Skin titration (RINKEL method); cytotoxicity testing (Bryan's test); MAST testing; urine auto-injections; subcutaneous or sublingual provocative and neutralization testing for allergies
- **Chiropractic care:** Except for manual manipulation of the spine for subluxation, and X-rays ordered by a chiropractor to diagnose subluxation of the spine
- **Circumcision:** For non-medically indicated reasons after one (1) month of age
- **Clinical trials:** Services not covered by Blue Cross NC
- **Custodial care:** The provision of room and board, nursing care, and personal care designed to assist member in the activities of daily living; or such other care which is provided to member who, in the opinion of Blue Cross NC, has reached the maximum level of physical or mental function and will not make further significant improvement. This includes custodial care rendered in the home and adult day care facilities.
- **Dental services:** All dental services, unless otherwise specified, including bridges, dentures, crowns, treatment for periodontal disease, dental root form implants, root canals, orthodontic appliances or any other treatment primarily to align teeth, appliances, orthognathic surgery (unless deemed medically necessary) or extraction of wisdom teeth except as provided in the member Evidence of Coverage; treatment for teeth which are chipped or broken from biting or chewing; and anesthesia for dental procedures, except as provided in the member Evidence of Coverage
- **Foot care:** All routine foot care unless otherwise specified, including corn and callous removal; nail trimming; and other hygienic or maintenance care; cleaning, soaking and skin cream application for ambulatory and bed-confined patients unless covered by Original Medicare

Continued ▶

- **Hospice:** Not covered by Blue Cross NC. A Medicare beneficiary with Medicare Part A may elect traditional Medicare hospice coverage (through traditional Medicare, not Blue Cross NC) and can decide to keep Blue Medicare coverage for services not related to the terminal illness, or elect traditional Medicare coverage for everything by disenrolling from Blue Medicare. Claims for all hospice-related services must be billed to traditional Medicare, not Blue Cross NC.

  Note: Even though traditional Medicare covers the services related to the terminal illness, Blue Cross NC will provide the member with a listing of Medicare-certified hospice providers in their area.
- **Lenses:** Contact lenses or the fitting thereof, except for the first pair of lenses or eyeglasses following a cataract operation, unless otherwise specified (this may include contact lens or placement of intraocular lens)
- **Long-term skilled care services:** Skilled care services in the home that do not qualify as part-time or intermittent, as defined by Medicare, or skilled care services in a skilled nursing facility or unit, or a sub-acute facility or unit, for a period exceeding one hundred (100) days per benefit period (beginning with the first day a member received these services)
- **Naturopathy:** An alternative treatment form using techniques such as diet control, exercise and massage
- **Obesity:** Services and drugs in connection with obesity, including but not limited to non-medically necessary surgical procedures such as gastric bypass surgery or balloon insertion and removal; and experimental services and complications. Surgical treatment of morbid obesity is eligible for coverage when medically necessary. This includes services specifically used for treatment of obesity, except other services and treatments within standard medical practice policies or covered by Original Medicare and which are authorized and approved by Blue Cross NC.
- **Occupational injury or sickness:** The cost of services for any injury which occurs in the work place, or a sickness which occurs as a result of employment, normally covered under workers' compensation or other employer's liability laws. Should a member have the cost of services denied by one (1) of the above insurance programs, Blue Cross NC will consider payment of covered services. Blue Cross NC will not cover the cost of services that were denied by the above insurance programs for failure to meet administrative or filing requirements.
- **Certain organ transplants:** Experimental/investigational transplants. Combined kidney and liver transplant is not covered. Coverage is limited to Medicare covered services. Pancreas transplantation for diabetic patients who have not experienced end-stage renal failure secondary to diabetes continue to be excluded from Medicare.

Continued ▶

- **Orthopedic shoes:** Unless covered by Medicare (for individuals with diabetic foot disease) or part of a leg brace and included in the cost of the leg brace
- **Orthotics:** Foot orthotics, i.e., custom shoes or custom inserts for shoes or boots except as covered by Original Medicare or as specified in the member Evidence of Coverage
- **Personal comfort or convenience items, convenience fees, household fixtures and equipment and member refused items and services:** Chairs, personal comfort or convenience items such as household fixtures and equipment or related services and supplies not directly related to the care of the member, including but not limited to guest meals and accommodations; telephone charges; travel expenses; take-home supplies and similar costs; health and fitness club expenses provided to members; convenience products for injections; home or vehicular evaluations and modifications to meet the environmental needs of the member or caregiver; fees charged by providers for services, supplies or equipment requested by member, but later refused by member. The purchase or rental of household fixtures, including but not limited to: Exercise equipment; air purifiers; central or unit air conditioners, water purifiers; humidifiers/dehumidifiers; hypoallergenic pillows; whirlpools and spas; and mattresses or waterbeds unless covered by Original Medicare.
- **Prosthetic and corrective devices:** Prosthetics that are primarily for patient convenience or are more costly than equally effective alternative equipment. Blue Cross NC and Medicare coverage determinations will be used.
- **Religious, marital, family and sex counseling:** Services and treatment related to religious counseling, family counseling, marital/relationship counseling, sex therapy, adoption and pastoral counseling unless covered by Original Medicare
- **Respite care:** Medical care required to be arranged for, and provided to, a patient whose condition has not changed (i.e., is stable) due only to the fact that the patient's caregiver is absent
- **Sclerotherapy:** Except when covered by Original Medicare as medically necessary and previously approved by Blue Cross NC
- **Services furnished under a private contract:** Services (other than for emergency or urgently needed services) furnished by a physician as defined by the Social Security Act who has filed with the Medicare carrier an affidavit promising to furnish Medicare covered services to Medicare beneficiaries only through private contracts with the beneficiaries under section 1802(b) of the Social Security Act

Continued ▶

- **Services the member is not legally obligated to pay, and services performed by a relative:** Any service for which the member legally would not be required to pay in the absence of this coverage; services performed by a relative of member
- **Treatment in a federal, state or governmental entity:** To the extent allowed by applicable laws, coverage for care and treatment provided in a hospital owned or operated by any federal, state or other governmental entity, and care of military service-connected conditions for which the member is legally entitled to services. This includes services provided to veterans in Veterans Affairs (VA) facilities. However, reimbursement is allowed for the cost sharing for emergency services received at a VA hospital, up to the appropriate cost sharing under the plan.
- **Vehicular modifications:** Unless covered by Medicare
- **Vision:** Vision care, except as provided by Original Medicare or as specified in the member's Evidence of Coverage. This exclusion/limitation includes, but it is not limited to: Eye exercises; visual training; orthoptics; and all types of contact lenses or corrective lenses unless specified in this Evidence of Coverage.
- **Weight control:** All services and supplies for the purpose of weight control; weight management and commercial weight loss/reduction programs, unless covered by Original Medicare

13.16
Using the correct NPI for reporting your health care services

The National Provider Identifier (NPI) is a HIPAA mandate for electronic transactions. The NPI is a ten (10) digit unique health care provider identifier. Additional information about NPI can be found at the CMS website at ***www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Instructions-for-Notice-of-Medicare-Non-Coverage-NOMNC.pdf***.

Electronic transactions and paper both require NPI

There are two (2) types of NPI that are assigned via the CMS enumeration system, National Plan and Provider Enumeration System (NPPES):

- **Type 1:** Assigned to an individual who renders health care services, including physicians, nurses, physical therapists and dentists. An individual provider can receive only one (1) NPI.
- **Type 2:** Assigned to a health care organization and its subparts that may include hospitals, skilled nursing facilities, home health agencies, pharmacies and suppliers of medical equipment (durable medical equipment, orthotics, prosthetics, etc). An organization may apply and receive multiple NPIs to support their business structure.

13.17
Using the correct claim form for reporting your health care services

Blue Cross NC recognizes and accepts the CMS-1500 (02-12) claim form or other similar forms for professional providers and the UB-04 (CMS-1450) claim form for institutional/facility providers. The National Uniform Billing Committee (NUBC) approved these forms that accommodate the reporting of the NPI as replacements for the forms predecessors, CMS-1500 (02-12) and UB-04.

Most providers, billing agencies or computer vendors file claims to Blue Cross NC electronically using the HIPAA-compliant 837 formats. Providers who are not set up to file claims electronically should refer to the chart below to determine the correct paper claim form to use:

Item	Explanation
Ambulance provider	**CMS-1500 (02-12) claim form or other similar forms**
Home durable medical equipment (HDME)	**CMS-1500 (02-12) claim form or other similar forms**
Licensed registered dietitian	**CMS-1500 (02-12) claim form or other similar forms**
Provider's office	**CMS-1500 (02-12) claim form or other similar forms**
Reference lab	**CMS-1500 (02-12) claim form or other similar forms**
Specialty pharmacy	**CMS-1500 (02-12) claim form or other similar forms**

Continued ▶

Item	Explanation
Dialysis provider	**Form UB-04 (CMS-1450)**
Hospital facility	**Form UB-04 (CMS-1450)**
Hospital-owned ambulance services	**Form UB-04 (CMS-1450)**
Lithotripsy provider	**Form UB-04 (CMS-1450)**
Skilled nursing facility	**Form UB-04 (CMS-1450)**
Ambulatory surgical center	**Form UB-04 (CMS-1450) or CMS-1500 (02-12) claim form or other similar forms**
Home health care:	
Home health provider	**Form UB-04 (CMS-1450)**
Private duty nursing	**Form UB-04 (CMS-1450)**
Home infusion provider	**CMS-1500 (02-12) claim form or other similar forms**
Home health physician	**CMS-1500 (02-12) claim form or other similar forms**

For more information on the CMS-1500 (version 02-12) claim form or other similar forms or the UB-04 claim form, visit the National Uniform Claim Committee (NUCC) website at *www.nucc.org*.

Independent Diagnostic Testing Facility (IDTF): An IDTF is a facility that is independent both of an attending or consulting physician's office and of a hospital.

Billing: Provider bills one claim for technical component only at locations listed in their contract.

13.17.1
CMS-1500 (02-12) claim form or other similar forms claim filing instructions

Field number	Description
1	Leave blank.
1a	Insured's ID - Enter the member identification number exactly as it appears on the patient's ID card. The member's ID number is the letter J followed by the subscriber number and the two-digit (2-digit) suffix listed next to the member's name on the ID card. This field accepts alpha and numeric characters.
2	The patient's name should be entered as last name, first name and middle initial.
3	Enter the patient's birth date and sex. The date of birth should be eight (8) positions in the MM/DD/YYYY format. Use one (1) character (X) to indicate the sex of the patient.
4	Enter the name of the insured. If the patient and insured are the same, then the word "same" may be used. This name should correspond with the ID # in field 1a.
5	Enter the patient's address and telephone number.
6	Use one (1) character (X) to indicate the patient's relationship to the insured.
7	Enter insured's address and telephone number. If patient's and insured's address are the same then the word "same" may be used.
8	Enter the patient's marital and employment status by marking an (X) in one (1) box on each line.

Continued ▶

Field number	Description
9	Show the last name, first name, and middle initial of the person having other coverage that applies to this patient. If the same as Item 4, enter "same" (complete this block only when the patient has other insurance coverage). Indicate "none" if no other insurance applies.
9a	Enter the policy and/or group number of the other insured's policy.
9b	Enter the other insured's date of birth (MM/DD/YYYY) and sex.
9c	Enter the other insured's employer's name or school name.
9d	Enter the other insured's insurance company name.
10a-c	Use one (1) character (X) to mark yes or no to indicate whether employment, auto accident or other accident involvement applies to services in Item 24 (diagnosis).
11	Enter member's policy or group number.
11a	Enter member's date of birth (MM/DD/YYYY) and sex.
11b	Enter member's employer's name or school name.
11c	Enter member's insurance plan name.

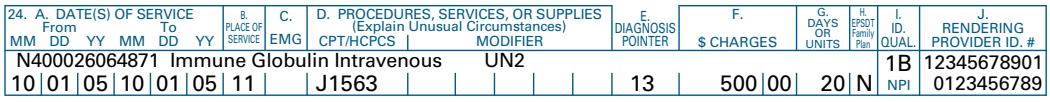
Continued ▶

Field number	Description
11d	Check yes or no to indicate if there is, or not, another health benefit plan. If yes, complete items 9 through 9d.
12	Have the patient or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the patient or other authorized person on file authorizing the release of any medical or other information necessary to process this claim.
13	Have the subscriber or authorized person sign or indicate signature on file in lieu of an actual signature if you have the original signature of the member or other authorized person on file authorizing assignment of payment to you.
14	Enter the date of injury or medical emergency. For conditions of pregnancy enter the last menstrual period (LMP). If other conditions of illness, enter the date of onset of first symptoms.
15	If patient has previously had the same or similar illness, give the date of the previous episode.
16	Leave blank.
17	Enter name of referring physician or provider.
17a	Enter ID number of referring physician or provider.

Continued ▶

Field number	Description
17b	Enter 1B (Blue Cross NC ID qualifier) in the shaded area and to the immediate right of 17a. Enter the Blue Cross NC ID number of the referring provider in the shaded box to the right of the ID qualifier. (This field is only required if the NPI number is not reported in Box 17B.) Example: 17a. | 1B | 12345 17b. | NPI | 1234567891
18	If services are provided in the hospital, give hospitalization dates related to the current services.
19	Leave blank.
20	Complete this block to indicate billing for clinical diagnosis tests.
21	Enter the ICD indicator to identify the version of ICD codes being reported. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Enter the codes left justified on each line to identify the patient's diagnosis and/or condition. Do not include the decimal point in the diagnosis code, because it is implied. List no more than twelve (12) ICD-10-CM diagnosis codes. Relate lines A – L to the lines of service in 24E by the letter of the line. Use the greatest level of specificity. Do not provide narrative description in this field. The "Diagnosis or Nature of Illness or Injury" is the sign, symptom, complaint or condition of the patient relating to the service(s) on the claim. This field allows for the entry of a one (1) character indicator and twelve (12) diagnosis codes at a maximum of seven (7) characters in length. Example: 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. 0139 B. 06012x0 C. J0190 D. E. F. G. H. I. J. K. L. $0 claims for additional diagnoses with asterisk.

Continued ▶

Field number	Description
22	Leave blank.
23	Enter certification of prior review number here if services require it.
24	The six (6) service lines in Section 24 have been divided horizontally to accommodate submission of both the NPI number and Blue Cross NC identifier during the NPI transition, and to accommodate the submission of supplemental information to support the billed service. The top area of the six (6) service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of twelve (12) lines of service. Use of the supplemental information fields should be limited to the reporting of National Drug Codes (NDC). If reporting NDC numbers, report the NDC qualifier "N4" in supplemental field 24a followed by the NDC code and unit information (UN = unit; GR = gram; ML = milliliter; F2 = international unit). Example:  24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # N400026064871 Immune Globulin Intravenous UN2 1B 12345678901 10 01 05 10 01 05 11 J1563 13 500 00 20 N NPI 0123456789
24a	Enter the month, day and year (six [6] digits) for each procedure, service and/or supply in the unshaded date fields. Dates must be in the MM/DD/YY format.
24b	Enter the appropriate place of service codes in the unshaded area.
24c	Leave blank.
24d	Enter procedure, service or supplies using the appropriate CPT or HCPCS code in the unshaded area. Also enter, when appropriate, up to four (4) two-digit (2-digit) modifiers.

Continued ▶

Field number	Description
24e	Enter the diagnosis reference number (pointer) in the unshaded area. The diagnosis pointer references the line number from field 21 that relates to the reason the service(s) was performed (ex. 1, 2, 3 or 4, or multiple numbers if the service relates to multiple diagnoses from field 21). The field accommodates up to four (4) digits with no commas between numbers.
24f	Enter the total charges for each line item in the unshaded area. Enter up to six (6) numeric positions to the left of the vertical line two (2) positions to the right. Dollar signs are not required.
24g	Enter days/units in the unshaded area. This item is most commonly used for units of supplies, anesthesia units, etc. Anesthesia units should be one (1) unit equals a one-minute (1-minute) increment. Do not include base units of the procedure with the time units. If you are billing services for consecutive dates (from and to dates), it is critical that you provide the units accurately in block 24g.
24h	Leave blank.
24i	Enter 1B (Blue Cross NC ID qualifier) in box 24i above the dotted line (not required if submitting NPI number).
24j	Enter the assigned Blue Cross NC provider identification number for the performing provider in the shaded area. If several members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service. (This field is only required if the NPI number is not being reported.) Enter the NPI number of the performing provider below the dotted line. If several members of the group shown in Item 33 have furnished services, this item is to be used to distinguish each provider of service. Example:

I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1B	
NPI	12345678901

Continued ▶

Field number	Description
25	Enter federal tax identification number. [X] Indicate whether this number is a Social Security Number (SSN) or Employer Identification Number (EIN).
26	Enter the patient account number assigned by physician's/provider's/supplier's accounting system.
27	Accept assignment. [X] Yes must be indicated in order to receive direct reimbursement. Contracting providers have agreed to accept assignment.
28	Enter the total charges for all services listed on the claim form in item 24F. Up to seven (7) numeric positions can be entered to the left of the vertical lines and two (2) positions can be entered to the right. Dollar signs are not required.
29	Enter the amount paid by the primary insurance carrier. (Reminder: Only copayments may be collected at time of service.)
30	Enter total amount due – charges minus any payments received.
31	Include signature and date of the physician/provider/supplier. (Stamped signatures are accepted.)
32	Enter the name and address of the facility site where services on the claim were rendered. This field is especially helpful when this address is different from billing address in Item 33.
32a	Enter the NPI number of the service facility.

Field number	Description
32b	Enter the ID qualifier 1B immediately followed by the Blue Cross NC assigned five-digit (5-digit) provider identification number for the service facility (this field is not required if submitting the NPI number in Field 32a). Example: 32. SERVICE FACILITY LOCATION INFORMATION CRABTREE MEDICAL CENTER 100 AIRPORT ROAD RALEIGH, NC 27610 a. 12344567891 b. 1B01234
33	Enter the name, address and phone number for the billing provider or group.
33a	Enter the NPI number of the billing provider or group.
33b	Enter the ID qualifier 1B immediately followed by the Blue Cross NC assigned five-digit (5-digit) provider identification number for the billing provider or group (this field is not required if submitting the NPI number in Field 33a). Example: 33. BILLING PROVIDER INFO & PH # ( ) DR. JUDD KILGORE P O BOX 1678 RALEIGH, NC 27610 a. 1987654321 b. 1B03456

13.17.2
Sample CMS-1500 (02-12) claim form

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** CR061653 APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

13.17.3
UB-04 claim filing instructions

Form locator number	Description of content
1	• Provider name • Street address or post office box • City, state, zip code • (Area code) telephone number
2	Required when the address for payment is different than that of the billing provider information located in form locater box 1 above. • Pay-to name • Pay-to address • Pay-to city, state, zip
3a	Provider assigned patient control number.
3b	Provider assigned medical/health record number (if available).
4	**Type of bill (4 digit classification)** • **Digit 1: Leading zero** • **Digit 2: Type of facility** – 1 = Hospital – 2 = Skilled nursing facility – 3 = Home health – 7 = Clinic – 8 = Special facility • **Digit 3: Bill classification** – 1 = Inpatient – 3 = Outpatient – 4 = Other • **Digit 4: Frequency** – 1 = Admit through discharge claim – 2 = Interim - first claim – 3 = Interim - continuing claim – 4 = Interim - last claim – 5 = Late charge

Please refer to the NUBC UB-04 for official data specifications.

Continued ▶

Form locator number	Description of content
5	Provider's federal tax identification number.
6	Date(s) of service (enter MMDDYY, example 010106).
7	Leave blank.
8a	Patient ID (required if different than the subscriber/insured ID in form locator 60).
8b	Patient's name (last name, first name, middle initial).
9a	Patient's address – street.
9b	Patient's address – city.
9c	Patient's address – state.
9d	Patient's address – zip.
9e	Patient's address – county code (if outside US). (Refer to USPS Domestic Mail Manual).
10	Patient's date of birth (enter MMDDYYYY, example 01012006).
11	Patient's sex (M/F/U).
12	Admission/start of care date (MMDDYY).

Form locator number	Description of content
13	**Admission hour** Code Time A.M. / Code Time P.M. 00 12:00-12:59 midnight / 12 12:00-12:59 noon 01 01:00-01:59 / 13 01:00-01:59 02 02:00-02:59 / 14 02:00-02:59 03 03:00-03:59 / 15 03:00-03:59 04 04:00-04:59 / 16 04:00-04:59 05 05:00-05:59 / 17 05:00-05:59 06 06:00-06:59 / 18 06:00-06:59 07 07:00-07:59 / 19 07:00-07:59 08 08:00-08:59 / 20 08:00-08:59 09 09:00-09:59 / 21 09:00-09:59 10 10:00-10:59 / 22 10:00-10:59 11 11:00-11:59 / 23 11:00-11:59
14	**Type of admission/visit** 1. Emergency 2. Urgent 3. Elective 4. Newborn 5. Trauma 9. Information not available
15	**Source of admission or visit** 1. Physician referral 2. Clinic referral 3. HMO referral 4. Transfer from a hospital 5. Transfer from a skilled nursing facility 6. Transfer from another health care facility 7. Emergency room 8. Court/law enforcement 9. Information not available A. Transfer from a critical access hospital B. Transfer from another home health agency C. Readmission to same home health agency D. Transfer from hospital inpatient in the same facility resulting in a separate claim to the payer

Continued ▶

Form locator number	Description of content
15 (continued)	**For newborns** 1. Normal delivery 2. Premature birth 3. Sick baby 4. Extramural birth
16	**Discharge hour** Code Time A.M. / Code Time P.M. 00 12:00-12:59 midnight / 12 12:00-12:59 noon 01 01:00-01:59 / 13 01:00-01:59 02 02:00-02:59 / 14 02:00-02:59 03 03:00-03:59 / 15 03:00-03:59 04 04:00-04:59 / 16 04:00-04:59 05 05:00-05:59 / 17 05:00-05:59 06 06:00-06:59 / 18 06:00-06:59 07 07:00-07:59 / 19 07:00-07:59 08 08:00-08:59 / 20 08:00-08:59 09 09:00-09:59 / 21 09:00-09:59 10 10:00-10:59 / 22 10:00-10:59 11 11:00-11:59 / 23 11:00-11:59
17	**Patient discharge status** 01 – Discharged to home/self care (routine discharge) 02 – Discharged/transferred to hospital 03 – Discharged/transferred to skilled nursing facility 04 – Discharged/transferred to an intermediate care facility 05 – Discharged/transferred to another type of institution 06 – Discharged/transferred to home under care of home health 07 – Left against medical advice 20 – Expired 30 – Still patient 43 – Discharged/transferred to a federal health care facility 50 – Hospice – home 51 – Hospice – medical facility (certified) providing hospice level of care 61 – Discharged/transferred to a hospital-based Medicare approved swing bed 62 – Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part units of a hospital

Continued ▶

Form locator number	Description of content
17 (continued)	63 – Discharged/transferred to a Medicare certified long-term care hospital (LTCH) 64 – Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare 65 – Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 66 – Discharged/transferred to a critical access hospital (CAH)
18-28 (as applicable)	**Condition codes** 09 – Neither patient nor spouse is employed 11 – Disabled beneficiary but no Large Group Health Plan (LGHP) 71 – Full care in unit C1 – Approved as billed C5 – Post payment review applicable C6 – Admission pre-authorization
29	**Accident state (situational)** Required when the services reported on this claim are related to an auto accident, and the accident occurred in a country or location that has a state, province or sub-country code.
30	Leave blank.
31-34 (as applicable)	**Occurrence codes and dates** 01 – Accident/medical coverage 02 – No fault insurance involved 03 – Accident/tort liability 04 – Accident employment related 05 – Accident no medical/liability coverage 06 – Crime victim **Medical condition codes** 09 – Start of infertility treatment cycle 10 – Last menstrual period (only applies for maternity related care) 11 – Onset of symptoms/illness

Please refer to the NUBC UB-04 for official data specifications.

Continued ▶

Form locator number	Description of content
31-34 (as applicable) (continued)	**Insurance related codes** 24 – Date insurance denied 25 – Date benefits terminated by primary payer **Covered by Employer Group Health Plan (EGHP)** A1 – Birthdate of primary subscriber B1 – Birthdate of second subscriber C1 – Birthdate of third subscriber A2 – Effective date of the primary insurance policy B2 – Effective date of the secondary insurance policy C2 – Effective date of the third insurance policy
35-36 (as applicable)	**Occurrence span codes and dates** 70 – Qualifying stay dates for SNF use only 71 – Prior stay dates 72 – First/last visit dates 74 – Non-covered level of care/leave of absence dates
37	Leave blank.
38	Responsible party name and address.

Please refer to the NUBC UB-04 for official data specifications.

Form locator number	Description of content
39-41	**Value codes** 01 – Most common semi-private rooms 02 – Provider has no semi-private rooms 08 – Lifetime reserve amount in the first calendar year 45 – Accident hour 50 – Physical therapy visit A1 – Inpatient deductible Part A A2 – Inpatient coinsurance Part A A3 – Estimated responsibility Part A B1 – Outpatient deductible B2 – Outpatient coinsurance
42	Revenue code (refer to UB-04 manual).
43	Revenue description (refer to UB-04 manual).
44	**HCPCS/rates** • The HCPCS applicable to ancillary service and outpatient bills • The accommodation rate for inpatient bills
45	**Service date (MMDDYY)** • Applies to lines 1-22 **Creation date (MMDDYY)** • Applies to line 23 – the date bill was created / printed
46	Unit of service.
47	Total charges by revenue code category (0001 = total charges should be reported on line 23 with the exception of multiple pages which should be reported on line 23 of the last page).
48	Non-covered charges.

Please refer to the NUBC UB-04 for official data specifications.

Continued ▶

Form locator number	Description of content
50 (A, B, C)	**Insurance carrier name (payer)** • Line A - primary payer • Line B - secondary payer • Line C - tertiary payer
51	Health plan identification number (leave blank until mandated).
52 (A, B, C)	**Release of information** • **I** = Informed consent to release medical information for conditions or diagnoses (signature is not on file) • **Y** = Provider has a signed statement permitting release of medical/billing date related to a claim
53 (A, B, C)	**Assignment of benefits** • N = No • Y = Yes (must be indicated in order to receive direct reimbursement) • Contracting providers have agreed to accept assignment
54 (A, B, C)	**Prior payments/source** • A - Primary payer • B - Secondary payer • C - Tertiary payer
55 (A, B, C)	Estimated amount due (not required).
56	National provider identifier (NPI) – billing provider.
57 (A, B, C)	Other billing provider ID (Blue Cross NC provider number on appropriate line) – required if NPI is not reported on FL56.
58 (A, B, C)	Subscriber's/insured's name (last name, first name).

Continued ▶

Form locator number	Description of content
59 **(A, B, C)**	**Patient's relationship to subscriber/insured** 01 – Spouse 18 – Self 19 – Child 20 – Employee 21 – Unknown 39 – Organ donor 40 – Cadaver donor 53 – Life partner G8 – Other relationship
60 **(A, B, C)**	Subscriber's/insured's identification number.
61 **(A, B, C)**	Subscriber's/insured's group name.
62 **(A, B, C)**	Subscriber's/insured's group number.
63 **(A, B, C)**	Treatment authorization code.
64 **(A, B, C)**	Document control number (DCN) [leave blank].
65 **(A, B, C)**	Subscriber's/insured's employer name.
66	Diagnosis and procedure code qualifier (ICD version indicator).

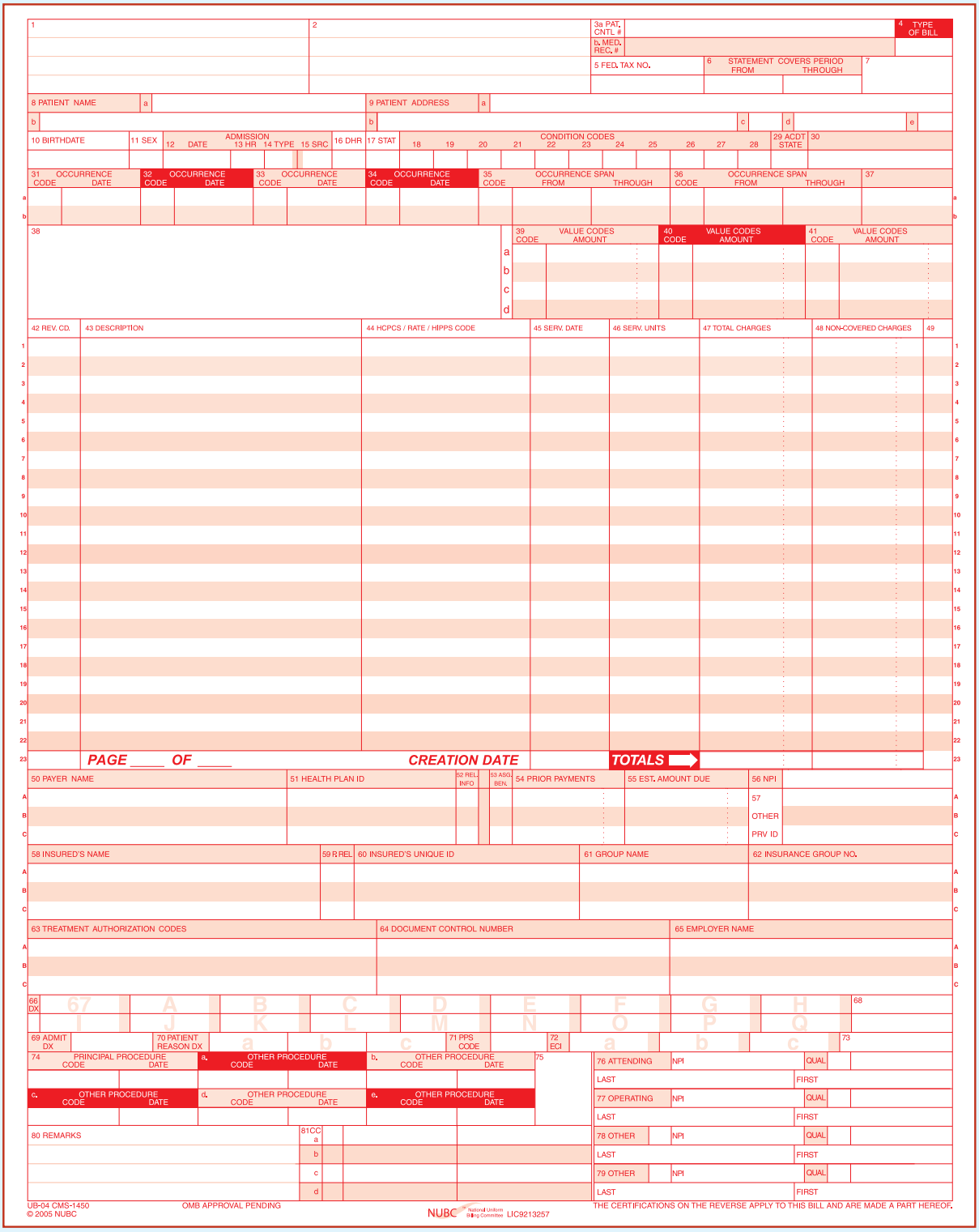
Continued ▶

Form locator number	Description of content
67	Principal diagnosis code "ICD-10" (do not enter decimal, it is implied). • Eighth (8th) position indicates Present on Admission indicator (POA) – not required for Blue Cross NC commercial business – Y = Yes – N = No – U = No information in the record – W = Clinically undetermined
67 (A-Q)	Other diagnosis codes "ICD-10." • Eighth (8th) position indicates Present On Admission indicator (POA) – required for inpatient claims – Y = Yes – N = No – U = No information in the record – W = Clinically undetermined
68	Leave blank.
69	Admitting diagnosis (inpatient only).
70 (A, B, C)	Patient's reason for visit (outpatient only).
71	Prospective payment system (PPS) code [not required].
72 (A, B, C)	External cause of injury code "E-Code."
73	Leave blank.

Continued ▶

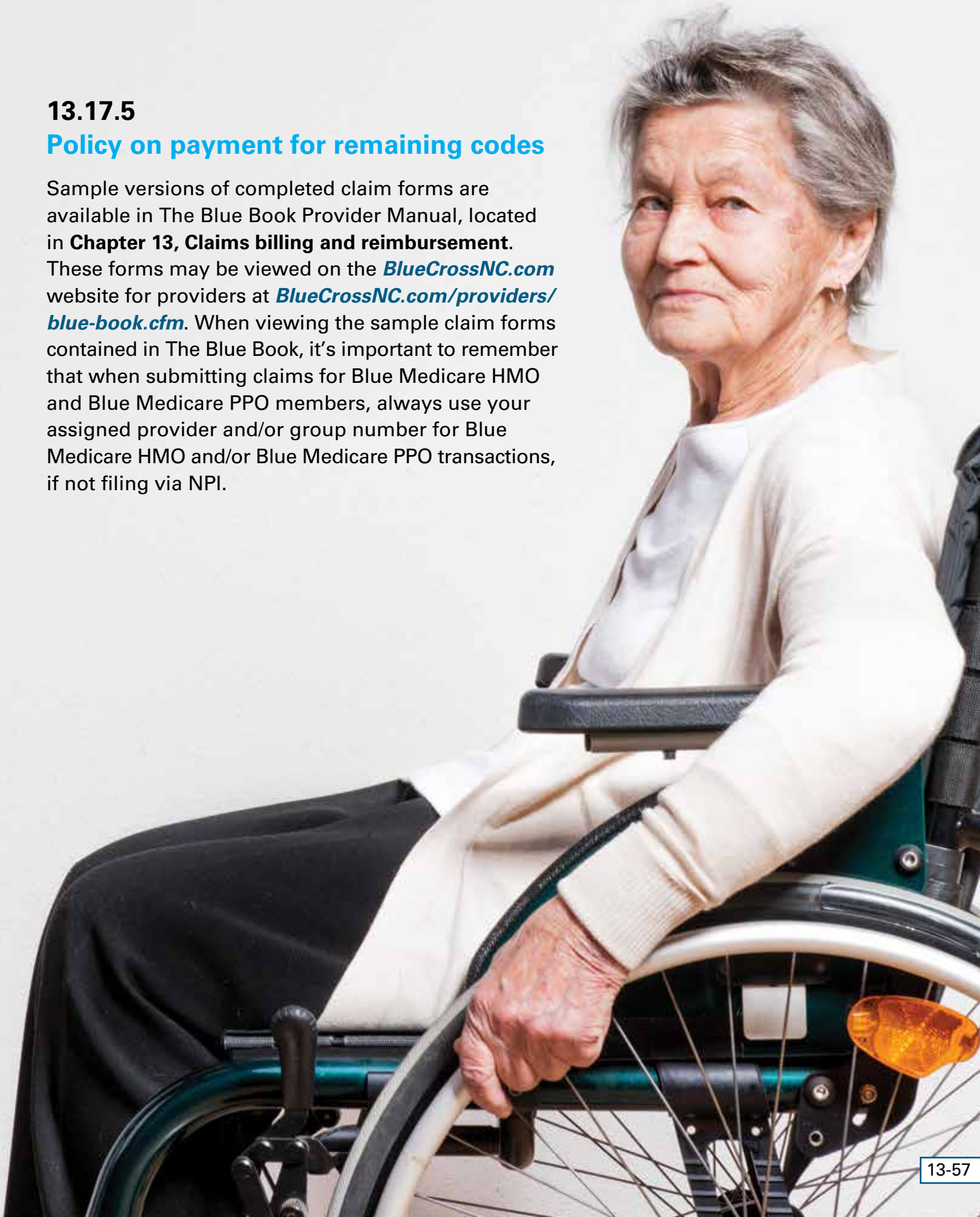
Form locator number	Description of content
74	Principal procedure code and date. • ICD-10 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format MMDDYY
74 (A-E)	Other procedures codes and dates (procedures performed during the billing period other than those coded in FL74). • ICD-10 code required on inpatient claims when a procedure was performed (do not enter decimal, it is implied) • Leave blank for outpatient claims • Date format MMDDYY
75	Leave blank.
76	Attending physician (NPI, last name and first name). • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
77	Operating physician (NPI, last name and first name). • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
78-79	Other physician (NPI, last name and first name). • If NPI is not reported, report 1G in the secondary identifier qualifier field and UPIN in the secondary identifier field
80	Remarks.
81 (A-D)	Code - code field (overflow field to report additional codes).

13.17.4
Sample UB-04 claim form



13.17.5
Policy on payment for remaining codes

Sample versions of completed claim forms are available in The Blue Book Provider Manual, located in **Chapter 13, Claims billing and reimbursement**. These forms may be viewed on the ***BlueCrossNC.com*** website for providers at ***BlueCrossNC.com/providers/blue-book.cfm***. When viewing the sample claim forms contained in The Blue Book, it's important to remember that when submitting claims for Blue Medicare HMO and Blue Medicare PPO members, always use your assigned provider and/or group number for Blue Medicare HMO and/or Blue Medicare PPO transactions, if not filing via NPI.



13.18
HCPCS codes

Reminder:

Blue Cross NC has been and will continue to allow the submission of HCPCS codes. In fact, their use is encouraged especially when filing for the administration of medications.

When submitting claims with a medication code of "**J**," it is important to refer to the HCPCS code book, paying particular attention to the dose that is listed to ensure appropriate reimbursement exactly as they appear in the HCPCS book.

When submitting claims with a medication code of "J," it is important to:

- File units rather than milligrams
- Include the NDC number
- Include a description or name of the medication
- Include dose given

The claim cannot be processed without these vital pieces of information and may be denied for medical justification.

13.19
ICD-10 and CPT codes for well exams

When filing claims for well exams, you must use the correct ICD-10 and CPT codes. Please refer to the most current AMA CPT coding books to ensure you are using the most appropriate and valid ICD-10 and CPT codes.

Preventive medicine codes include counseling.

Diagnosis codes:

- ICD-10 general medical examination code Z00.00 or Z00.01 (adults, age eighteen [18] and over) and Z00.129 (children, newborn to seventeen [17] years of age) should be used as the primary code for services that are predominantly preventive
- ICD-10 code Z01.411 or Z01.419 should be used as the diagnosis code for the annual routine pelvic examinations including pap smears

Procedure codes:

- Preventive medicine codes 99385-99387 and 99395-99397 must be used when ICD-10 code Z00.00 or Z00.01, adult preventive care, is the primary or submitted diagnosis; 99381-99384 and 99391-99394 must be used when ICD-10 code Z00.121 or Z00.129, pediatric preventive care, is the submitted diagnosis
- CPT evaluation and management service codes 99202-99205 and 99211-99215 should be used when services are predominantly for patient complaints and/or illness and should be selected according to criteria described in the CPT manual

Initial preventive physical examination (IPPE) or Welcome to Medicare visit:

- CPT code G0402 is used to bill the IPPE visit. The Welcome to Medicare visit is billed only within the first twelve (12) months the member has had Medicare.

Annual wellness visits (AWV):

- G0438 is used for the initial AWV and must occur at least twelve (12) months after the member's Welcome to Medicare visit
- G0439 is used for the subsequent AWV
- AWVs are allowed once per year

13.20
Immunizations (Part D-covered vaccines)

Physicians and other providers who bill Medicare carriers or Medicare administrative contractors (A/B MACs) for the administration of Part D-covered vaccines to Medicare cannot bill Medicare Part B (i.e., Blue Cross NC medical claims) for the administration of Medicare Part D-covered vaccines. Providers billing staff should be aware of Part D-covered vaccine administration guidance. Section 202(b) of the Tax Relief and Health Care Act of 2006 (TRHCA) established a permanent policy for payment by Medicare for administration of Part D-covered vaccines, beginning in 2008. Specifically, the policy states that effective January 1, 2008, the administration of a Part D-covered vaccine is included in the definition of "covered Part D drug" under the Part D statute. During 2007, in transition to the policy, providers were permitted to bill Part B for the administration of a Part D vaccine using a special G code (G0377). However, special edition (SE) 0723 reminds providers of the requirement that payment for the administration of Part D-covered vaccines was only during 2007. Therefore, effective January 1, 2008, and dates after, providers may no longer bill the "G" code to Part B, instead the Part D plan should be billed for reimbursement.

13.20.1
Safe handling of vaccines

Vaccines for immunizations can be temperature sensitive and should be monitored for temperature increases and decreases until they are administered. Blue Medicare HMO and Blue Medicare PPO members are not to pick-up vaccines from the pharmacy for transport to a provider's office, as this may result in unsafe temperature changes. Vaccines may only be obtained by the administering provider and never by a Blue Medicare HMO or Blue Medicare PPO member. Providers with questions are encouraged to contact their provider network representative.

13.20.2
Medicare Part D vaccine manager for claims filing

Participating providers have an easy online option to submit Medicare Part D vaccine claims through ***e***Dispense™. ***e***Dispense Part D vaccine manager, a product of Dispensing Solutions, Inc. (DSI), is a web-based application that offers a solution for the submission and adjudication of claims for physician administered Part D vaccine covered by member's Medicare Part D pharmacy benefits (vaccination claims that cannot be submitted on a standard CMS-1500 medical claim form or other similar forms).

Continued ▶

eDispense makes real-time claims processing for in-office administered Medicare Part D vaccines available through its secure online access. Services offered with ***e***Dispense allow providers to quickly and electronically verify a member's Medicare Part D vaccination coverage and submit claims to our pharmacy benefits manager directly from your in-office internet connection.

eDispense offers providers the ability to:

- Verify members' Medicare Part D vaccination eligibility and benefits in real-time
- Advise members of their appropriate out-of-pocket expense for Medicare Part D vaccines
- Submit Medicare Part D vaccine claims electronically to our pharmacy benefits manager (PBM)

Enrollment is an easy two (2) step process:

- **Step 1** – select an authorized staff member who is most likely to be the primary user of the system to enroll the practice. This person should be prepared to provide the following information about the practice:
  - Tax identification number
  - National provider identifier (NPI)
  - Medicare ID number
  - Drug Enforcement Administration (DEA) number
  - State medical license number
- **Step 2** – go to Dispensing Solutions' website and complete a simple one-time online enrollment application at *mytransactrx.com/WebPortal/logout.do*

Providers can contact Dispensing Solutions directly for assistance with enrollment and claims by calling their Customer Support Center at **1-866-522-EDVM (3386)**.

Provider enrollment in ***e***Dispense vaccine manager and ***e***Dispense facilitated transactions between the PBM and providers is a voluntary option for providers. Medicare Part D vaccine claims eligible for electronic processing with ***e***Dispense Part D vaccine manager are reimbursed according to the PBM allowance, less member liability. Blue Cross NC offers network providers access to ***e***Dispense vaccine manager for Medicare Part D transactions through our PBM.

13.21
Allergy testing

All allergy testing for members must be provided by participating allergists who are board certified by the American Board of Allergy and Immunology, or participating board certified ENT allergists who have completed requirements for fellowship in the American Academy of Otolaryngic Allergy (AAOA) and have been approved by the Blue Cross NC credentials committee.

The following are the exceptions:

- Allergy patch testing has been approved to be performed by our participating dermatologists. CPT code is 95044.
- Ophthalmic mucous membrane testing has been approved to be performed by our ophthalmologists. CPT code is 95060.
- Inhalation bronchial challenge testing has been approved to be performed by our participating pulmonary specialists. CPT code is 95070.

Subsequent allergy injections may be provided by other participating physicians such as the primary care physician or other participating specialists when referred by the primary care physician.

CPT codes used for allergy testing are 95004-95070.

CPT codes used for allergy immunotherapy are 95115-95180.

Skin tests for specific drug immediate reactions would be appropriate for any participating physician specialty.

13.22
Criteria for approving additional providers for allergy testing

- To certify that allergy testing throughout the Blue Cross NC network of otolaryngic providers is performed in a consistent manner, and by physicians who have been adequately trained in evaluation of allergic manifestations, the need has arisen for standardization of criteria for credentialing of privileges by otolaryngologists
- Blue Cross NC will recognize and approve allergy testing to otolaryngologists who are participating providers in the Blue Cross NC network and who have fulfilled the requirements and received certification by the AAOA. Verification of certification by the AAOA should be provided by the otolaryngologist upon application for privileges for otolaryngic allergy testing.
- **Background:** Allergy testing for Blue Cross NC members can be an important of determining causes of significant illnesses, as well as being the basis for selecting a treatment regimen for members who exhibit allergic manifestations. After review of available information, it appears appropriate and reasonable to expect otolaryngic providers to have gone through the requirements of the AAOA and to receive certification as ENT allergists in order to be certified as a participating provider of otolaryngic allergy testing.
- Exceptions may be made, on an individual basis, by the Blue Cross NC credentialing committee based on evidence of sufficient training and experience in the field of ENT allergy

13.23
Use of office or other outpatient service code 99211

CPT code 99211 is described as "office or other outpatient visit for evaluation and management of an established patient, that may not require the presence of a physician." Usually the presenting problems are minimal. Typically five (5) minutes are spent performing or supervising these services.

The CPT code should not be used for an additional charge when only laboratory, immunizations or other diagnostics are performed.

For Blue Cross NC patients, this service code requires a copayment to be charged and patients should not have to pay a copayment if they are only reporting for laboratory tests or X-rays.

For the service described by CPT code 99211 to be billed:

- There should be a documented service by the physician or physician office staff that is separate from other procedures that are being performed at the same time, such as injections and diagnostic tests
- The service should be clearly identifiable
- A record of the service performed should be entered into the patient's medical record

Examples:

- Office visit for a sixty-seven (67)-year-old established patient to re-dress an abrasion
- Office visit of a seventy-two (72)-year-old established patient, for a blood pressure check and review medication

13.24
Dispensing DME from the office

Prior authorization will not be required for covered durable medical equipment (DME) or medical supply items if the item is:

- $1,200 or less by contracted rate, and
- Filed with a valid HCPCS code, and
- Filed by a participating provider/vendor

Prior authorization is required for all DME greater than $1,200 for payment by Blue Cross NC. Unlisted, miscellaneous or customized items will not have a contracted price as they are priced based on individual consideration; therefore, these items generally will require prior authorization. This allows us to make a determination of coverage and inform you of the member's copayment. To pre-authorize the item, call Care Management at **1-888-296-9790** with the following information:

- Name of item required and the HCPCS code
- Diagnosis
- What the device will be used for
- Clarification that the device is medically necessary

You may bill the member if services are denied as non-covered. These services are excluded in the member's Evidence of Coverage.

You may not balance bill the member if services denied exceeds HMO guidelines or are considered included in a global service.

You should not have any problem receiving reimbursement for the HCPCS "L" codes submitted if you prior authorize the DME. Be aware that all authorized HCPCS "L" code devices are considered durable medical equipment and the applicable DME copayment/coinsurance will be deducted by Blue Cross NC at the time of claims submission.

13.25
Assistant surgery

Following are Blue Medicare HMO and Blue Medicare PPO criteria for reimbursement for assistant surgery procedures:

- The practitioner assisting surgery must be credentialed by and participating with Blue Medicare HMO and Blue Medicare PPO, but does not have to be the same specialty or have training equal to the primary surgeon. The assistant surgeon is expected to comply with all applicable statutes and regulations as appropriate for assistant surgery.
- Physician reimbursement is limited to 16% of the Blue Medicare allowable for the CPT code submitted by the primary surgeon or charges, whichever is less. Multiple surgery guidelines apply to assistant surgeons when they are assisting on multiple procedures. Physician reimbursement for the second procedure is limited to 8% of the Blue Medicare allowable or charge, whichever is less. Reimbursement for mid-level practitioners providing assistant surgery is limited to 85% of the assistant surgeon physician allowable for primary and multiple procedures.
- The plan utilizes assistant surgeon indicators identified by industry standard coding software to determine if the procedure indicates the use of an assistant surgeon. When assistant at surgery services are eligible for reimbursement, providers are to bill using industry standard modifiers.

13.26
Prior authorization requirements

For Blue Medicare HMO and Blue Medicare PPO members, authorization of certain outpatient services such as home health, durable medical equipment, rehabilitation and requests for non-participating providers may be required prior to the initiation of services. Please verify member benefits and review Blue Cross NC prior authorization requirements detailed in this manual in **Chapter 9, Prior authorization requirements**, prior to providing services.

13.27
Ancillary billing

13.27.1
Participating reference lab billing

Definition – Reference clinical laboratory testing services as may be requested by Blue Cross NC participating providers. This would include, but not be limited to, consulting services provided by provider, courier service, specimen collection and preparation at designated provider locations, and all supplies necessary solely to collect, transport, process or store specimens to be submitted to provider for testing.

Continued ▶

Billing

- Bill on CMS-1500 claim form or other similar forms using CPT/HCPCS coding
- Specify services provided and include all of the statistical and descriptive medical, diagnostic and patient data
- Use appropriate provider number
- File claims after complete services have been provided
- Laboratory procedure reimbursement includes the collection, handling and conveyance of the specimen
- All services provided should be billed as global

13.27.2
Dialysis services billing

Definition – For services involved in the process of removing blood from a patient whose kidney functioning quality is faulty, purifying that blood by dialysis and returning it to the patient's bloodstream.

Billing – Provider agrees to:

- Billing on the UB-04 claim form using only those revenue codes indicated as billable dialysis facility services, along with the corresponding CPT codes and HCPCS codes
- Not bill for routine laboratory, pharmaceutical and supplies that Medicare considers to be included under the composite dialysis rate (dialysis inclusive rate)
- Bill for non-routine (separately billable) laboratory and pharmaceuticals that Medicare considers to be not included under the composite dialysis rate

The in-home hemodialysis inclusive rate per treatment is the same as the in-center hemodialysis inclusive rate per treatment.

13.27.3
Skilled Nursing Facility (SNF) billing

Definition – Skilled nursing care is care and/or skilled rehabilitation services, which must be furnished by or under the supervision of registered or licensed personnel and under the direction of a physician to assure the safety of the member and achieve the medically desired result. Skilled rehabilitation therapy includes services provided by physical therapists, occupational therapists and speech pathologists or audiologists. The member must require continuous (daily) skilled nursing services for the level of care to be considered covered.

Billing

- Bill on UB-04 claim form
- The patient must require continuous (daily) skilled nursing services for the level of care to be considered covered
- The medical record will contain documentation substantiating coding classification, such as in the form of a completed minimum data set (MDS) scoring tool
- The following exclusionary services require prior approval from Blue Cross NC health service department: Specialty beds, DME for personal and/or home use, customized prosthetics and orthotics, ambulance transport, diagnostic procedures and lab work not routinely carried out by the facility

13.27.4
Ambulatory Surgical Center (ASC) billing

Definition – Surgical procedures grouped by complexity (as defined by Medicare).

Billing

- Outpatient surgery, radiology, laboratory and other diagnostic services must be billed by CPT code
- Providers should always submit the appropriate CPT code to indicate the primary procedure
- All ancillary services and supplies provided in conjunction with an ambulatory surgical procedure, including those delivered within seventy-two (72) hours prior to the surgical procedure, must be billed on the same UB-04 form

Incidental procedure – An incidental procedure is one that is carried out at the same time as a more complex primary procedure and requires little additional resources and/or is clinically integral to the performance of the primary procedure. For these reasons, an incidental procedure should not be reimbursed separately on a claim. Procedures that are considered incidental when billed with related primary procedures on the same date of service will be denied. Incidental procedures are identified by medical review and are considered a contractual adjustment.

Integral procedure – Procedures considered integral occur in multiple surgery situations when one (1) or more of the procedures are considered an integral part of the major or principle procedure. Integral procedures are considered to be those commonly carried out as part of a total service and will not be reimbursed separately.

13.27.5
Home DME and billing

Definition – Durable medical equipment services are defined by CPT codes, and by HCPCS codes as set forth in the AMA HCPCS Level I and Level II guidelines.

Billing – Bill on a CMS-1500 claim form.

Payment – rentals

- All rentals and all rentals converted to purchase require prior authorization
- Always include rental modifier code on rental claim forms
- Bill rental services monthly as one (1) unit after thirty (30) consecutive days of rental, or at the time the rental is determined to no longer be medically necessary (whichever is first)

Payment – repairs/maintenance

- Non-routine repairs that require the skill of a technician may be eligible for reimbursement
- The labor component of the repair should be billed under the appropriate repair code
- All replacement parts should be billed separately under the appropriate HCPCS code(s)
- Repairs may only be billed on purchased items and require prior authorization
- Repairs may not be billed on rented equipment
- All claims with a repair code should be submitted with a complete description of the services provided
- When submitting a claim with a repair or maintenance modifier code and other modifier codes, file the maintenance modifier code in the primary modifier position
- Losses resulting from abuse/misuse of equipment or items are excluded from coverage
- Maintenance services require prior authorization

Certain drugs and supplies

With the implementation of Medicare Part D, which is Medicare prescription drug coverage, certain drugs and supplies are covered only under the Blue Cross NC member's prescription drug benefits.

This means that providers need to know whether or not they are in-network for the prescription drug benefits, as well as be able to distinguish between Medicare Part B and Part D coverage in order to know how to bill properly for a given drug or supply.

In order to be in-network for the Medicare Part D prescription drug benefits, DME providers must be in the Prime Therapeutics®, LLC (Prime) network. Prime is Blue Cross NC's Part D pharmacy benefits manager. DME providers who contract only with Blue Cross NC, but not with Prime, are in-network only for Part B benefits and are out-of-network for Part D benefits. DME providers that are also pharmacies that would like to participate with Prime may contact Prime directly at **1-877-277-7893** or by email to: *PharmacyOps@PrimeTherapeutics.com*.

Continued ▶

When billing for the drugs and supplies that are covered under Medicare Part B, providers need to follow all Medicare Part B coverage guidelines. Providers must follow the Medicare Part D coverage guidance when billing for drugs and supplies that are covered under Medicare Part D.

Modifier RP applicable to purchased items only

- Modifier RP must be filed when submitting claims for maintenance and repairs

Miscellaneous

- For manual and motorized wheelchairs and scooters, the plan has the right to authorize these items as rental items if Medicare has rental rates

Use of E1399 and other miscellaneous codes

Do not use E1399 or other miscellaneous HCPCS codes for items which have a designated HCPCS code.

- Special documentation is required for claims using miscellaneous codes, including E1399

  Always submit:

  1. With each claim a complete description of the item
  2. With each initial claim a factory invoice for the item (catalogs and retail price listings are not acceptable)

- Failure to provide appropriate documentation when using E1399 and other miscellaneous codes can result in processing delays and/or denials

Please Note:

- Do not staple these or any other enclosures to the claim form
- Submit all initial claims on paper to ensure the appropriate documentation is received in the same envelope
- Electronically submitted claims will not transmit additional documents

13.27.6
Home Health (HH) billing

Definition – Home health services are defined as follows:

Visits to the home to provide skilled services, including:

Home Health Services	Must Be Rendered By
Skilled Nursing (SN)	**Registered nurse or licensed practical nurse**
Physical Therapy (PT)	**Licensed physical therapist or licensed physical therapist assistant**
Occupational Therapy (OT)	**Licensed occupational therapist**
Speech Therapy (ST)	**Licensed speech pathologist**
Medical Social Service (MSW)	**Medical social service (MSW)**
Medical Social Service (MSW)	**Home health aide**

Billing – Provider agrees to:

- Bill on UB-04 claim form. Appropriate HCPCS codes are required in box 44 of the UB-04 in order to receive payment
- Bill your retail charges
- Use your appropriate provider number
- File claims after complete services have been provided
- In addition to the home health visit, bill only the non-routine medical supplies listed in the agreement. These are the only covered supplies that may be billed under the revenue codes listed (all other covered supplies are considered routine). If on prospective payment contract, FFS contract can file intermittent claims.
- Blue Cross NC will not pay overtime/holiday rates, travel time or mileage
- For non-routine supplies, include a valid HCPCS code with the revenue code on the UB-04

Continued ▶

Revenue codes and service units

Service	Revenue Code	Payment
Home health aide	571	Visit
Medical social worker	561	Visit
Occupational therapy	431	Visit
Physical therapy	421	Visit
Skilled nursing LPN	550	Visit
Skilled nursing RN	551	Visit
Speech therapy	441	Visit

Home health services not billable as separate services (integral part of home health visit):

- Routine medical supplies provided in conjunction with home health services including those left at the member's home are considered an integral part of the home health visit reimbursement and cannot be billed separately (under Home Durable Medical Equipment [HDME] provider number or any other provider number)
- Assessment visits unless a skilled service is also rendered during the same visit
- Supervisory visits unless a skilled service is also rendered during the same visit
- Skilled nursing visits may not be billed on the same days as private duty nursing visits

Billable non-routine home health supplies

Routine medical supplies provided in conjunction with home health services including those left at the member's home are considered an integral part of the home health visit reimbursement and cannot be billed separately (under HDME provider number or any other provider number).

13.27.7
Home Infusion Therapy (HIT) billing

Definition – Home infusion therapy is infusion services the member receives in the home. Home infusion therapy is defined as follows:

- The administration of prescription drugs and solutions initiated and administered in the home via one (1) of these routes:
  - Intravenous
  - Intraspinal
  - Epidural
  - Subcutaneous

Home infusion is on the prior review list. Therefore, certain home infusion therapy services require prior review prior to services being rendered. When requesting authorization, the request needs to be specific and cover the following elements listed above.

Benefits for home infusion services are limited. The following is applicable only to services that have been authorized by Blue Cross NC.

Billing

- Home infusion therapy requiring regular nursing services must be billed in three (3) components by the home infusion therapy provider:
  - Per diem component (covering all home infusion services, equipment and supplies except the prescription drug and licensing nursing services) for each day the drug is **infused**
  - Nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN), and
  - Drug component (only bill for the quantity of drug actually administered, not unused mixed, compounded or opened quantities)

Notice: Other medications eligible for reimbursement under the home infusion therapy (HIT) schedule must be injections administered during the same visit as the infusion therapy and require administration by a health care provider such as an RN or LPN.

- Bill on the CMS-1500 claim form or other similar forms
- Use your appropriate provider number
- File claims after services have been provided
- File claims within one hundred and eighty (180) days of providing service
- Miscellaneous codes are valid for use only if no suitable billing code is available. All claims using miscellaneous codes must be submitted with a complete description of the services rendered, including the NDC numbers for the drugs administered. Failing to provide appropriate documentation when using miscellaneous codes can result in delays and/or denials.
- Infusion services initiated in a clinic setting may not be billed under the member's home infusion benefit and must be billed incidental to the office visit. See MLN Matters 7397- Pharmacy Billing for Drugs Provided "Incident To" a Physician Service.

Do not use Blue Cross NC home infusion codes for Medicare supplemental members.

Bundled services

The following are included in the home infusion therapy rates established in your contract and reimbursement schedule and may not be billed separately unless defined:

- All training and nursing visits and all nursing services
- Initial assessment and patient set-up
- Providers may not request members obtain supplies or treatment from an office; to get supplies/treatment, home infusion must be done in the home

13.28
Hospital policies

The following are excerpts from the hospital agreement that outlines the provider's responsibility as a participating facility. These policies are provided in addition to the remainder of the policies in this manual. Please review all sections of this manual that pertain to you.

Access to medical records

The hospital agrees, as stated in the hospital agreement, that Blue Cross NC shall have the right, upon request and during normal business hours, to inspect and copy records maintained by the hospital pertaining to claims for hospital services.

Concurrent review

The hospital will participate in and cooperate with Blue Cross NC in its Utilization Management and Quality Improvement programs. Summaries of these programs follow.

Credentialing

The hospital will participate in and cooperate with Blue Cross NC credentialing and recredentialing processes, and will comply with determinations made pursuant to the same. Please also see **Chapter 19, Credentialing**.

The hospital will complete requests for verifications of privilege status regarding individual providers. These verifications will include information regarding a provider's:

- Status and standing with hospital
- Specialty classification
- Level of privileges
- Description of past actions
- Description of limitations

13.29
Utilization Management (UM) program

Blue Cross NC has developed and implemented a UM program with the objective of assuring that medical services delivered to Blue Cross NC members are timely, appropriate and cost-effective.

UM applies to all covered members. For inpatient services, UM activities include pre-admission and admission review, continued stay or concurrent review and discharge planning.

Pre-admission review is designed for monitoring and evaluating the medical necessity, appropriateness and required level of care for an elective admission prior to its occurrence. The patient's primary care physician or the consulting specialist typically initiates this process by obtaining authorization through Blue Cross NC Care Management department.

Admission review and concurrent review are performed by Blue Cross NC staff and are coordinated through the hospital's utilization review department.

Concurrent review is a review of the member's medical record by Blue Cross NC nurses during hospitalization to assess the continued medical necessity and appropriateness of care. This information is also used to begin the discharge planning process.

Blue Cross NC's primary objective of discharge planning is to help patients, their families, health care professionals and the community to ensure that the gains achieved from hospital care are maintained or enhanced for the continued health and welfare of the patients following discharge. The discharge plan is a process where patients' needs are identified, evaluated and assistance given in preparing them to move from one level of care to another.

During the discharge planning process, Blue Cross NC nurses assist in arranging and authorizing the services needed upon discharge. They work with the attending physicians, hospital discharge planners or social workers, the patients and their families and Blue Cross NC participating home health vendors to coordinate the services that are covered by Blue Cross NC.

Continued ▶

The nurses follow the ongoing treatment, status and needs of the patient until services are no longer needed or covered.

Retrospective review or claims review may also be conducted as part of the UM process. This process reviews the necessity and appropriateness of medical services by compilation and analysis of data after medical care is rendered to determine practitioner and consumer patterns of care.

If a hospital cannot provide adequate services to a Blue Cross NC member seeking provider services from a hospital, the hospital shall cooperate with the Blue Cross NC member and the participating physician who ordered the Blue Cross NC member's admission or treatment in obtaining appropriate care for the Blue Cross NC member. Referrals shall be made to a participating provider if required services are available from such a facility.

13.30
Medical eye care

Blue Cross NC is contracted with Community Eye Care to provide medical/routine vision care to Blue Cross NC members using a panel of optometrists and ophthalmologists.

- No referral needed
- Direct access to contracting ophthalmologists and optometrists
- Routine vision
- Medical surgical

Community Eye Care can be reached at **1-888-254-4290**.

13.31
Mental health / substance use management programs

Mental health and substance use services do not require a referral from the primary care physician. Contact us at **888-296-9790** to determine any UM required for mental health and substance use services.

13.32
Laboratory services

Reference labs:

If a specimen is drawn and the laboratory work is sent to a reference lab, the only service billable to Blue Cross NC is the administrative/handling charge (i.e., 36415 - Venipuncture). The reference lab will bill directly to Blue Cross NC for the service(s) it provides.

In-office labs:

If you are performing the laboratory service in your office, and your lab is Clinical Laboratory Improvement Amendments (CLIA) certified, the services can be filed directly with Blue Cross NC for reimbursement. Selected counties are subject to Blue Cross NC laboratory office allowable lists. Under that program, only procedures included in the appropriate office allowable lists can be billed directly to Blue Cross NC. Questions regarding this lab program should be directed to your provider network representative.

13.33
Blue Cross NC office laboratory allowable list

If you are performing laboratory service in your office and your lab is CLIA certified, many lab services can be filed directly to Blue Cross NC for reimbursement.

However, services identified by Medicare as requiring CLIA certification are not eligible for reimbursement by Blue Cross NC Blue Medicare unless you have provided Blue Cross NC Blue Medicare evidence in advance of having the CLIA certification necessary for billing these services as CLIA approved for your laboratory. CLIA excluded means that the laboratory is not subject to CLIA edits. No CLIA certificate is required for CLIA excluded services.

Prior to performing in-office laboratory services, providers are encouraged to verify their laboratory CLIA certification and review the Blue Cross NC allowable service code list that's applicable to their laboratory CLIA certification. Blue Cross NC currently maintains allowable service code lists which display the in-office lab services a provider may bill Blue Cross NC. These lists are available on the Blue Medicare Providers pages of our website ***BlueCrossNC.com***.

13.34
Coverage policies and billing procedures for Blue Cross NC

13.34.1
Anesthesia

- May be charged individually as used or included in a charge, based on time
- A charge that is based on time must be computed from the induction of anesthesia until surgery is complete. This charge includes the use of equipment (e.g., monitors), all supplies and all gases
- Anesthesia stand-by services are not covered unless they are actually used. Bill anesthesia services using revenue code R370

13.34.2
Certified Registered Nurse Anesthetist (CRNA)

- Must be filed on a CMS-1500 claim form or other similar forms
- Minutes of time must be included
- Anesthesia codes must be submitted

13.34.3
Autologous blood

- Charges for autologous donations are covered when such services are rendered for a specific purpose (e.g., surgery is scheduled or the need for using autologous blood is documented) and then only if the patient actually receives the blood
- Prophylactic autologous donations and long-term storage (e.g., freezing components) for an indeterminate time period in case of future need are not considered eligible for benefits
- Blood used must be billed on the same claim as the related surgery charges

13.34.4
Autopsy and morgue fee

- Autopsy and morgue fees are not covered under Blue Cross NC certificates

13.34.5
Critical care units

The following conditions must be met to be considered a critical care unit:

- The unit must be in a hospital and physically separate from general patient care areas and ancillary service areas
- There must be specific written policies that include criteria for admission to and discharge from the unit
- Registered nursing care must be furnished on a twenty-four (24) hour basis. A nurse-patient ratio of one (1) nurse to two (2) patients per patient day must be maintained.
- A critical care unit is not a post-operative recovery room or a post-anesthesia room

The charge for critical care unit (i.e., coronary care or intensive care unit) has two (2) components:

- The room charge includes all items listed under acute care
- The nursing increment/equipment charge includes the use of special equipment (e.g., dinemapp, swan ganz, pressure monitor, pressure transducer monitor, oximetry monitor, etc.) cardiac defibrillators, oxygen, supplies (e.g., electrodes, guidewires, telemetry pouches) and additional nursing personnel

To ensure appropriate benefit payments, the critical care room charge should equal the corresponding routine room rate (i.e., either the routine semi-private or private rate). An accurate breakdown of these components ensures correct claims processing. Any claims received without a breakdown of these components may be returned for correction.

13.34.6
Diabetes education (inpatient)

- Admissions solely for the purpose of diabetic education are not covered under Blue Cross NC certificates

13.34.7
Dietary nutrition services

- Medically necessary nutritional counseling may be a covered benefit
- Other nutritional assessment services (e.g., Optifast) are not covered under Blue Cross NC certificates
- If covered nutritional counseling is included on the UB-04 claim form use revenue code R942

13.34.8
EKG

- The charge for EKG services includes the use of a room, qualified technicians and supplies (e.g., electrodes, gel)

13.34.9
Hearing aid evaluation

- Hearing aid evaluation, hearing aid fitting and hearing screening are not covered under Blue Cross NC certificates

13.34.10
Lab / blood bank services

- The charge for clinical laboratory must include the cost of all supplies related to the tests performed and a fee for the administration of the department
- Arterial puncture charge should be included in the charge for the test

13.34.11
Labor and delivery rooms

The labor room charge and delivery room charge must include the cost of:

- The use of the room
- The services of qualified technical personnel
- Linens, instruments, equipment and routine supplies

The hospital should not bill Blue Cross NC for an obstetrics room in addition to the labor room when patient is still in the labor room at the time of patient census.

13.34.12
Leave of absence days

- Blue Cross NC does not provide coverage for therapeutic leave of absence days occurring during an inpatient admission whether in connection with the convenience of the patient or the treatment of the patient
- This charge should be billed directly to the patient as it is the patient's liability
- If billed on the UB-04 claim form, use revenue code R180 with zero charge in form locator 47

13.34.13
Observation services

Observation beds are covered outpatient services when it is determined that the patient should be held for observation, but not admitted to inpatient status. Use the following guidelines when billing observation charges:

- Bill observation services under revenue code R762
- The charges related to an observation bed may not exceed the most prevalent semi-private daily room rate
- Blue Cross NC should not be billed for both an observation charge and a daily room charge for the same day of service
- Observation charges must include all services and supplies included in the daily room charge
- The daily room rate should not be billed for an observation patient sent home before the midnight census hour
- When a patient receives services in, and is admitted directly from an observation holding area, such services are considered part of inpatient care
- Fees for use of emergency room or observation holding area and other ancillary services provided are covered as a part of inpatient ancillaries

13.34.14
Operating room

- The operating room charge may be based on time or per procedural basis. When time is the basis for the charge, it must be calculated from the induction of anesthesia to the completion of the procedure
- Operating room services should be billed using revenue code R360

13.34.15
Outpatient surgery

- All ancillaries and supplies associated with an outpatient surgical procedure should be billed on one (1) claim. This includes use of facility (pre-operative area, operating room, recovery room), all surgical equipment, anesthesia, surgical supplies, drugs and nourishment.
- All charges associated with preoperative testing performed within seventy-two (72) hours of the surgical procedure should also be billed on the same claim with the ancillaries and supplies for outpatient surgery

13.34.16
Personal supplies

- Personal supplies include items not ordered by the physician or not medically necessary
- These items are not covered by Blue Cross NC health insurance. These items should be billed using UB-04 revenue code R999.
- Example of personal supplies include:
  - Hair brush
  - Mouthwash
  - Nail clippers
  - Powder
  - Razor
  - Shampoo and conditioner
  - Shaving cream
  - Shoe horn
  - Toothpaste
  - Toothbrush

13.34.17
Pharmacy

Please also refer to **Section 14.1.1, Blue Cross NC formulary** in **Chapter 14, Pharmacy and specialty networks**.

- All pharmacy charges should be billed to Blue Cross NC using revenue code R250-R259

13.34.18
Recovery room

- The charge for recovery room includes the costs of nursing personnel, routine equipment (e.g., oxygen) and supplies, monitoring equipment (e.g., blood pressure, cardiac and pulse oximeter), defibrillator, etc
- Warming systems (e.g., Bair Hugger Patient Warming System, hypo/hyperthermic unit, radiant warmer, etc.) should not be billed to Blue Cross NC or the patient

13.34.19
Emergency room services

- Charges for ER visits and services resulting in an admission must be billed on the UB-04 for the inpatient admission. These charges should not be split and billed separately.
- Charges for ER visits that do not result in an approved admission must be submitted separately for consideration of payment. These services will be subject to existing prudent layperson language and if approved will reimburse according to the current outpatient reimbursement for your facility.

13.34.20
POA indicators required

The CMS requires completion of the Present on Admission (POA) indicator for every diagnosis on an inpatient acute care hospital claim.

Hospitals providing care for Blue Medicare HMO and Blue Medicare PPO members are required to follow CMS' POA reporting guidelines when submitting claims for services provided to our members.

For inpatient acute care Prospective Payment System (PPS) discharges on or after October 1, 2008, certain diagnosis codes on claims could trigger a higher paying Diagnosis Related Groups (DRG) at the time of discharge (but not at the time of admission). The DRG that must be assigned to the claim will be the one that does not result in the higher payment.

Blue Medicare PPO and Medicare supplemental products should apply CMS POA adjudication logic. Providers will not be compensated for those services that are non-reimbursable as identified in CMS' hospital-acquired conditions and present on admission indicator reporting program, or successor program(s), in accordance with CMS payment policies.

13.34.21
Room and board

- The following are included in daily hospital service acute care and should not be billed as separate items to Blue Cross NC or its members:
  - Room and complete linen service
  - **Dietary service:** Meals, therapeutic diets, required nourishment, dietary consultation and diet exchange list
  - General nursing services including patient education such as instruction and materials. This does not include or refer to private duty nursing.
  - All equipment needed to weigh the patient (e.g., scales)
  - Thermometers, blood pressure apparatus, gloves, tongue depressors, cotton balls, pulse oximeters and other items typically used in the examination of patients
  - Use of examining and/or treatment rooms for routine examination
  - Routine supplies as a part of normal patient care
  - Administration of enemas and medications including IVs
  - Postpartum services
  - Recreation therapy
  - Enterostomal therapy (the costs of enterostomal supplies are covered ancillary items)

13.34.22
Special beds

- Bill these beds using UB-04 revenue codes R946 and R947
- The following beds are covered as a separate charge when medically necessary:
  - Bio-Dyne bed
  - Clinitron bed
  - Flexicare bed
  - Fluidair bed
  - Just Step mattress
  - Ken-Air bed

- Kinetic therapy bed
- Pegasus airwave system
- Restcue bed (Hill-Rom EFICA CC)
- Roto-Rest bed
- Therapulse bed

13.34.23
Special monitoring equipment

- Includes dinemapp, swan ganz, cardiac, pressure monitor and telemetry
- Charges include the use of supplies (e.g., electrodes, guidewires and telemetry pouches)
- When special monitoring equipment is used by a patient in routine or general accommodations, a separate monitoring equipment charge may be billed
- When a patient is using special monitoring equipment in the operating room, recovery room or anesthesia department and is transported to another ancillary department or a room, a separate monitoring equipment charge should not be billed
- Monitoring equipment used during transport is considered a continuation of services
- Set up fees that only represent personnel time are considered part of the procedure/treatment fee

13.34.24
Speech therapy

- Covered speech therapy services should be billed using UB-04 revenue code R440-R449
- The itemization must be submitted on the claim
- Speech therapy is covered only when used to restore function following surgery, trauma or stroke
- Speech therapy is not considered medically necessary treatment for the following diagnoses:
  - Attention disorder
  - Behavior problems
  - Conceptual handicap
  - Mental retardation
  - Psychosocial speech delay
  - Developmental delay
- To be considered eligible for coverage, speech therapy services must be delivered by a qualified provider of speech therapy services. A qualified provider is one who is licensed where required and is performing within the scope of the license.

13.34.25
Take-home drugs

- Blue Cross NC policies do not provide basic inpatient hospital benefits for take-home drugs

13.34.26
Take-home supplies

- Covered take-home supplies should be billed using UB-04 revenue code R273
- Blue Cross NC certificates do not provide basic inpatient hospital benefits for take-home items
- Benefits are provided for take-home items by major medical and extended benefits when these items are properly identified on the claim

14

Pharmacy and specialty networks

14.1.1
Blue Cross NC formulary medications

Blue Cross NC formulary is a list of drugs selected by Blue Cross NC in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Blue Cross NC will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Blue Cross NC network pharmacy, meets the definition of a Part D drug and other plan rules are followed.

14.1.2
Formulary changes / updates

To get updated information about the drugs covered by Blue Cross NC Medicare prescription drug coverage, please visit our website at ***BlueCrossNC.com/provider-home*** or call Customer Service at **1-888-296-9790**, Monday - Friday, 8 a.m. to 6 p.m. ET. An online drug search can be accessed from ***BlueCrossNC.com/provider-home***, and a printable version of the formulary is also available.

Blue Cross NC may add or remove drugs from our formulary during the year. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug (or move a drug to a higher cost-sharing tier), we must notify members who take the drug at least sixty (60) days before the date that the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a sixty (60) day supply of the drug. If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

To request a copy of the Blue Cross NC Medicare prescription formulary, please contact Customer Service at **1-888-296-9790**, or you may visit our website at ***BlueCrossNC.com/provider-home***.

14.1.3
Generic substitution policy

Most drugs which have generic equivalents are covered only at a generic reimbursement level. Prescribing generic drugs when available can mean significant savings for your patients and may improve adherence to chronic drug regimens.

14.1.4
Exceptions process

Blue Cross NC provides a process for situations when a member demonstrates a medical need for Blue Cross NC Medicare Advantage Prescription Drug Plan (MAPD) to make an exception to its standard plan terms. A member, member's authorized representative or member's prescribing physician may request an exception in one (1) of the following situations:

- Coverage of a drug not on the formulary (list of drugs the plan covers)
- Continued coverage of a drug that has been removed from the formulary for reasons other than safety or because the Part D prescription drug was withdrawn from the market by the drug's manufacturer
- Coverage of a drug requiring prior authorization or that requires step therapy
- Exceptions to quantity limits

To request an exception to the coverage rules for the member's Medicare prescription drug plan, the member or the member's prescribing physician may call or submit a written request.

The prescribing physician must submit a supporting statement verifying the exception is medically necessary to treat the enrollee's disease or medical condition. Corporate pharmacy will review the exception request as expeditiously as possible (within twenty-four [24] hours of receipt of clinical information for an expedited request, and within seventy-two [72] hours of receipt of clinical information for a standard [non-expedited] request). The member and prescribing physician will be notified orally of the coverage decision. If the request is denied, the member will receive written notice explaining the denial decision; providers may request a copy of this written notification as well. The notice will include details regarding Blue Cross NC's appeals process.

Physicians may request an exception by calling, faxing or writing to health services:

Telephone: **1-888-298-7552** for PDP; **1-888-296-9790** for MAPD

Fax: **1-888-446-8535**

Written requests:

Blue Medicare HMO
Attention: Exceptions - Care Management
P.O. Box 17509
Winston-Salem, NC 27116-7509

14.1.5
Prior authorization

Blue Cross NC requires prior authorization for certain drugs. Physicians on behalf of members may request prior authorization for these drugs. Designations that prior authorizations are required are indicated on the online drug search and printable formulary. Prior authorization criteria are posted at ***BlueCrossNC.com/provider-home***.

- For these drugs, prior authorization must be obtained prior to drug coverage at the pharmacy
- The physician or the physician's representative must contact Blue Cross NC to request prior authorization
- Within the timeline required by Blue Cross NC, the physician must supply a clinical supporting statement demonstrating the use of the drug meets criteria

14.1.6
Non-formulary requests

Non-formulary drug requests require members to use the drug for a medically acceptable use and, in general, to have tried and failed formulary alternatives in the same drug class. For non-formulary requests, the member or the member's prescribing physician may contact Blue Cross NC. A physician's supporting statement is required for all requests before the prescription can be considered for coverage. Tier exceptions cannot be granted for non-formulary drugs approved for coverage. Physicians may contact the plan by calling Blue Cross NC at **1-888-296-9790** or using the applicable fax request form to request an exception.

Blue Cross NC pharmacy fax forms can be accessed via the web at ***BlueCrossNC.com/content/medicare/member/policies/approval.htm***.

Medicare Advantage

Submit requests electronically through CoverMyMeds (CMM). Visit ***covermymeds.com*** and enter Plan/PBM Name: Blue Cross NC Medicare.

Prescription drug plan prior authorization requests and non-formulary drug requests:

Fax number: **1-888-446-8535**

Address:
Blue Cross NC
Attention: Part D Coverage Determinations
P.O. Box 17509
Winston-Salem, NC 27116-7509

Provider telephone: **1-888-296-9790**

14.1.7
Quantity limits

For certain drugs, Blue Cross NC limits the amount of the drug covered. For example, Blue Cross NC covers eighteen (18) tablets per thirty (30) days for prescriptions for sumatriptan 100mg tablets. If a patient requires a quantity in excess of the quantity limit, the physician must supply a statement supporting the clinical need for the higher quantity and any additional therapies being used to treat the patient's medical condition.

14.1.8
Step therapy

In some cases, patients are required to first try one drug to treat their condition before another drug is covered for that condition. If a prerequisite drug is not found in recent past claims, a drug requiring step therapy is not covered. The physician or physician's representative, on the patient's behalf, may contact Blue Cross NC to request coverage. A clinical supporting statement will be required stating that the patient has a documented intolerance, contraindication or hypersensitivity to the prerequisite drug(s), plus any additional clinical information regarding the patient's need for the step therapy drug. Step therapy may also be required on drugs that qualify as Part B drugs.

14.1.9
Drugs with Part B and Part D coverage

Some drugs can be covered under either Part B or Part D depending on the circumstances. Drugs that are currently authorized by law as covered under Part B will remain covered under Part B and should be billed to the Part B payer. For information about drugs covered under Part B, visit the CMS coverage database or DME-MAC Jurisdiction C webpage.

14.1.10
Request for drugs to be added to the formulary

To request an addition to the formulary, physicians may forward a written request indicating the advantage of the drug over current formulary medications to:

Blue Cross and Blue Shield of North Carolina
P.O. Box 17168
Winston-Salem, NC 27116-7509

14.1.11
Types of drugs not covered by prescription drug plans

Three general rules about drugs that Medicare drug plans will not cover under Part D:

1. Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books.

These reference books are:

The American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

If the use is not supported by either of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

14.2
Medication management programs

Members enrolled in Blue Medicare HMO and Blue Medicare PPO plans with Medicare prescription drug benefits or Blue Medicare Rx may be eligible for the Medication Therapy Management Program (MTMP), in accordance with CMS requirements. The purpose of the program is to provide medication therapy management services to targeted members. These services are designed to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes by improving medication use and reducing the risk of adverse drug events, including adverse drug interactions. The MTMP is developed in cooperation with licensed and practicing pharmacists and physicians.

The goals of the program are to educate members regarding their medications, increase member adherence to medication therapy, and identify and prevent medical complications related to medication therapy.

Individual members eligible for the MTMP services must meet all three (3) criteria:

- Have at least three (3) of the following chronic conditions: Diabetes, chronic obstructive pulmonary disease (COPD), high blood pressure, high blood cholesterol, chronic heart failure (CHF) or rheumatoid arthritis
- Take at least eight (8) or more prescription medications covered by Part D
- Expect to spend more than $4,376 in 2021 on prescription medicines covered by Medicare Part D

Continued ▶

Eligible members are automatically enrolled in the program. Eligible members will receive a welcome call as well a welcome packet that includes a participation form to request an appointment for a comprehensive medication review or to opt-out of the program. Participation in the program is voluntary, and the program and services are provided at no additional cost to the member. Members are encouraged to return the participation form in the envelope provided, or call a toll-free number (**1-866-686-2223** or TTY users call **711**) between 9 a.m. and 6 p.m. ET, Monday through Friday.

MTMP services include the following interventions for members and prescribers:

- An annual comprehensive medication review (CMR) which includes an interactive, person-to-person consultation via the telephone between the member and a pharmacist. The purpose of the CMR is to review all prescription and non-prescription medications the member is taking, provide education on their medications, identify care gaps and patterns of underuse or overuse and medication safety issues. After the CMR, the member is mailed a personalized medication list to carry to his or her provider visits as well as a summary of what was discussed.
- Quarterly targeted medication reviews (completed electronically on prescribed medications). Member's prescribers may be sent a letter about specific medication-related problems or about opportunities to optimize medication use.

14.2.1
The use of High Risk Medications (HRM) to help members safely use their opioid medications

We have a program that can help make sure our members safely use their prescription opioid medications and other medications that are frequently abused. This program is called a Drug Management program (DMP). If a member uses opioid medications that they get from several doctors or pharmacies, we may talk to their doctors to make sure their use of opioid medications is appropriate and medically necessary. Working with their doctors, if we decide the use of prescription opioid medications is not safe, we may limit how the member can access those medications.

The limitations may be:

- Requiring the member to get all their prescriptions for opioid medications from a certain pharmacy(ies)
- Requiring the member to get all their prescriptions for opioid medications from a certain doctor(s)
- Limiting the amount of opioid medications we will cover for the member

If we think that one or more of these limitations should apply to the member, we will send the member a letter in advance. The letter will have information explaining the limitations we think should apply. They will also have an opportunity to tell us which doctors or pharmacies they prefer to use, and about any other information they think is important for us to know. After they've had the opportunity to respond, if we decide to limit coverage for these medications, we will send another letter confirming the limitation. If the member thinks we made a mistake or disagrees with our determination that they are at-risk for

Continued ▶

prescription drug misuse or with the limitation, the member and their prescriber have the right to ask us for an appeal. If they choose to appeal, we will review the case and give them a decision. If we continue to deny any part of the request related to the limitations that apply to their access to medications, we will automatically send the case to an independent reviewer outside of our plan. See **Chapter 16** for information about how to ask for an appeal.

The DMP may not apply if members have certain medical conditions, such as cancer, are receiving hospice, palliative, or end-of-life care or live in a long-term care facility.

14.2.2 Medication adherence

Medication adherence is a program that monitors prescription claims for members and identifies those members whose adherence to a chronic maintenance medication falls below the 80% threshold based on prescription drug claims data. Blue Medicare may send a letter to the prescriber notifying them that a member has a gap in their refill history so that you can discuss this with your patient. In addition, a member may receive a phone call or mailing with an educational message about the importance of taking their medications to improve their health.

Examples of medication monitored through this program are oral and non-insulin medication for diabetes, renin angiotensin system antagonists for hypertension and statins for high cholesterol.

15

Post-service provider appeals

15.1
Level I post-service provider appeals

Post-service provider appeals consist of retrospective claim reviews and do not require a member signed authorization. Post-service provider appeals are performed based on a belief that a claim has been denied or adjudicated incorrectly.

The post-service provider appeal process is separate from the member appeals and grievance process and is listed in **Chapter 16** of this provider manual. If at any time the member files a post-service claim appeal during the review of a provider appeal, the member's appeal supersedes the provider appeal. Providers may not appeal items related to member benefit or contractual issues on their own behalf. Post-service provider appeals for review of a processed claim may be submitted for the following reasons:

- Coding/bundling, or fees
- Cosmetic
- Experimental/investigational
- Global period denial
- No authorization for inpatient admission
- Non-contracted provider payment dispute
- Not medical necessary
- Re-bundling
- Services not eligible for separate reimbursement

Level I post-service provider appeals for billing/coding disputes and medical necessity determinations are handled by Blue Cross NC and are available to physicians, physician groups, physician organizations and facilities. Providers have ninety (90) calendar days from the claim adjudication date to submit a Level I post-service provider appeal for billing/coding disputes and medical necessity determinations.

To request a review, contact Blue Cross NC using one of the following methods:

- Call the Provider Blue Line at **1-888-296-9790**
- Complete the Level I appeal form for Blue Medicare HMO and Blue Medicare PPO available to copy from the Forms section of this manual and for download from the ***BlueCrossNC.com*** website located at ***BlueCrossNC.com/provider-home*** (when sending to Blue Cross NC, include objective medical documentation)
- Mail a letter of explanation, including objective medical documentation, to the following address:

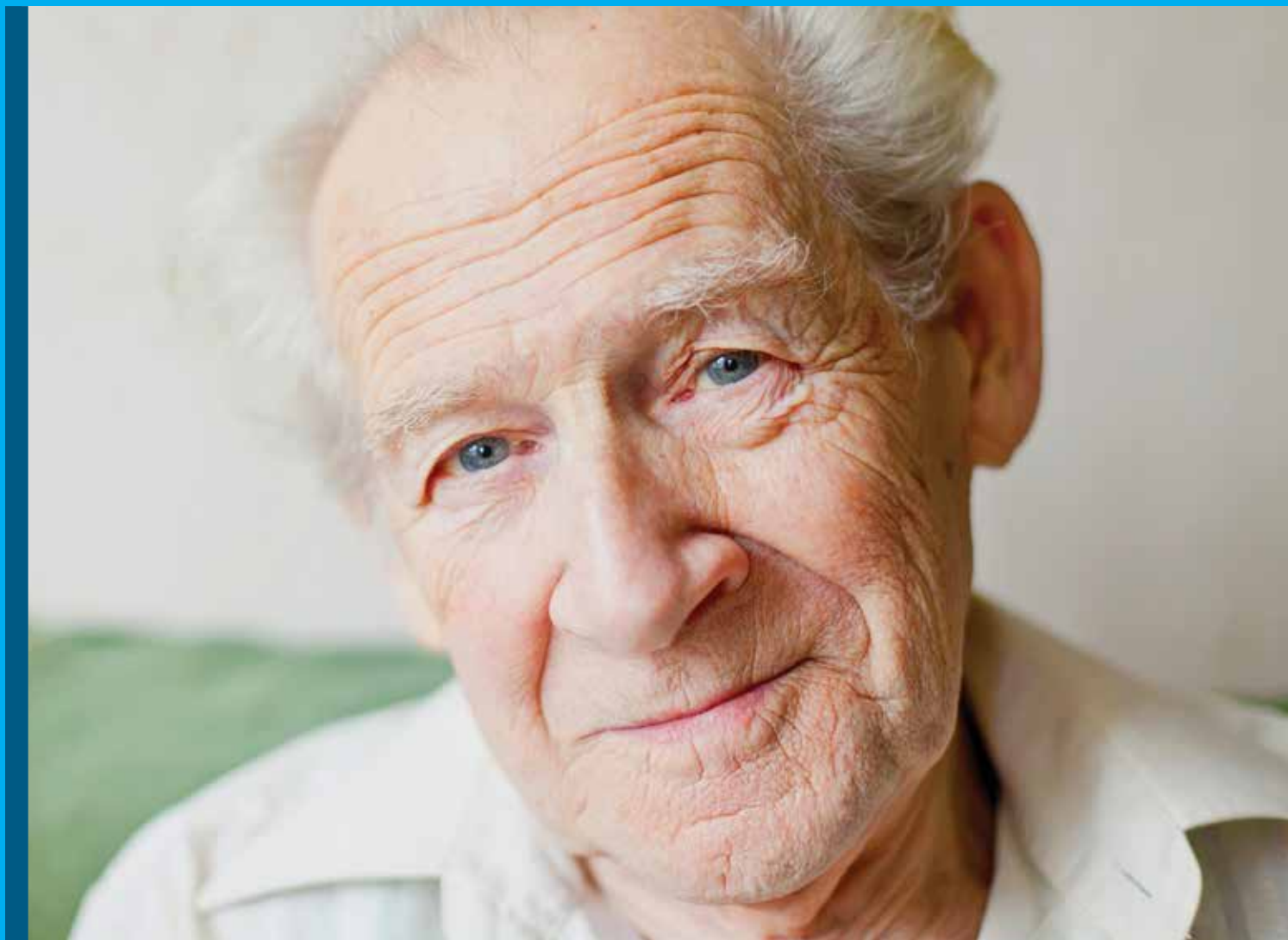
  Blue Cross and Blue Shield of North Carolina
  Provider Appeals Unit
  Blue Medicare HMO and Blue Medicare PPO
  P.O. Box 17509
  Winston-Salem, NC 27116-7509
- Fax your inquiries to:
  Provider Appeals Unit: **(919) 287-8815**

All inquiries regarding the status of an appeal should be routed through Customer Service.

Level I post-service provider appeals are handled within thirty (30) days from the date of receipt of all information. Supporting objective medical documentation should be submitted for post-service provider appeal reviews.

16

Member appeal and grievance procedures



16.1
Member grievances and appeals

Blue Cross NC members are encouraged to let Blue Cross NC know if they have questions, concerns or problems related to covered services or the care they receive. Members are also encouraged to first attempt to resolve issues about treatment though their primary care physician. If the member's issue cannot be resolved in this manner, the member has the right to file a formal complaint with Blue Cross NC.

16.2
What is an appeal?

An appeal is a request to change a coverage decision about what services are covered or what we will pay for a service. Appeals must be filed within sixty (60) calendar days from the date of the written denial notice. Each denial notice will include information on the member's right to file an appeal with instructions on how to do so. Once Blue Cross NC receives an appeal, it is handled through the mandated CMS appeal process.

16.3
Who can file an appeal?

A member or their authorized representative has the right to file an appeal through a formal process. If someone other than the member requests to file an appeal, the request is not valid until the member and the requesting party sign an appointment of representative form. The member's physician can file the appeal in addition to the member or their authorized representative. Appeals can be filed orally or in writing.

16.4
How quickly does Blue Cross NC handle an appeal?

CMS states that all appeals must be handled as quickly as the member's health requires. However, there are specific time frames for handling the different types of appeals after a valid request is received, For example:

- An appeal of a medical claim denial must be handled within sixty (60) calendar days after we receive the request
- An appeal of a medical service denial must be handled within thirty (30) calendar days after we receive the request unless an expedited or fast track appeal is requested. An expedited appeal must be handled within seventy-two (72) hours.
- An appeal of a medication covered under the member's medical benefits must be handled within seven (7) calendar days unless an expedited or fast track appeal is requested. An expedited appeal must be handled within seventy-two (72) hours.
- An appeal of a prescription drug denial must be handled within seven (7) calendar days unless an expedited or fast track appeal is requested. An expedited prescription drug appeal must be handled within seventy-two (72) hours.

16.5
What is a grievance?

A grievance is a type of claim that is made if a member is dissatisfied with any aspect of Blue Cross NC or with service or quality of care rendered by a contracting provider.

Only the member or their authorized representative may file a grievance. Blue Cross NC will respond to a grievance within thirty (30) calendar days after receipt. For expedited appeals, Blue Cross NC will respond within twenty-four (24) hours. Grievances from members about contracting providers may relate to a provider's compliance with Blue Cross NC procedures, personal relations between providers and members, access to medical care, service issues with the provider's office or potential medical quality problems. All grievances about providers are documented and placed in the provider's file for trending and review during credentialing. Every quality of care grievance is reviewed for further investigation when the provider in question is indicated.

16.6
What involvement does a contracting physician have with an appeal?

A contracting physician can be involved in an appeal in several ways:

- If a member files an appeal, they may ask their physician for support by asking the physician to write a letter on their behalf
- Blue Cross NC may contact the physician's office to obtain additional medical records for review during the appeal process. Quick compliance with this request is necessary as Blue Cross NC is required to handle an appeal as quickly as the member's health requires.
- If the case is sent to CMS's contracted independent review entity (IRE) for a decision, the IRE will ask for medical records if they do not believe all records have been submitted to them. Again, the requested records will need to be provided expeditiously.
- A physician may file an appeal on the member's behalf. The physician can do this by calling Blue Cross NC Customer Service, or by faxing an appeal request to **1-888-375-8836**.

Please note that neither the mandated CMS appeals process nor the grievance process is available to providers who have a dispute with Blue Cross NC over payment of a claim or over a contractual denial.

See **Chapter 13.13, Claims reimbursement disputes** for how to request a review of a claim or contractual denial for which the member has no financial liability.

17

Member rights and responsibilities

Blue Cross NC is committed to informing the providers of Blue Medicare HMO of the member's rights and responsibilities.

17.1
Member rights

1. You have the right to be treated with respect, dignity and consideration for your privacy by health care providers and by Blue Cross NC staff.
2. You have the right to receive information about the plan, its services, its health care providers and your rights and responsibilities as a member of the plan.
3. You have the right to private, confidential treatment of your records by plan staff and providers, and you have the right to access your medical records by contacting the provider of service.
4. You have the right to accessible services from the plan and from providers of health care, regardless of your English proficiency, reading skill, cultural or ethnic background and/or physical or mental disabilities.
5. You have the right to receive medically necessary services as described in your Blue Cross NC Blue Medicare HMO Evidence of Coverage agreement.
6. You have the right to coverage for emergency and urgently needed care without prior authorization using prudent layperson standards outlined in your Evidence of Coverage. (Refer to the Evidence of Coverage for details.)
7. You have the right to a second opinion if you question a contracting provider's decision about the need for surgery. A list of contracting providers can be found in the provider directory. With authorization from either your primary care physician or the plan a second opinion from the provider you select is covered.
8. You have the right to prompt resolution of any problems or complaints regarding Blue Cross NC Blue Medicare HMO or contracting providers via the plan's grievance process. You have a right to prompt resolution of any request for reconsideration or pre-service or claim denials via the Medicare appeals process. Questions about benefits, claims payment, contracting providers, plan services or the appeals and grievance procedures referenced above should be directed to a Blue Medicare HMO Customer Service representative by calling **1-888-310-4110** or **711** (TDD/TTY).

Continued ▶

9 You have the right to disenroll from Blue Medicare HMO, within guidelines governing restriction of election changes beginning January 1, 2002, by giving written notice to the plan of your intent to do so. Coverage will end on the first day of the month following the receipt of your request. To end your coverage, you may either:

(a) send written notice to

Blue Cross NC Blue Medicare HMO
P.O. Box 17509
Winston-Salem, NC 27116-7509; or

(b) disenroll at any Social Security Administration Office or Railroad Retirement Board Office

10 You have the right to continue coverage with Blue Medicare HMO, except in the following situations:

(a) non-payment of plan premiums,

(b) fraud,

(c) abuse of the organization's membership card,

(d) permanent moves outside the Blue Medicare HMO service area,

(e) loss of Medicare entitlement, or

(f) "for cause" subject to CMS approval

11 You have the right to participate with providers in making decisions about your health care and to receive information on available treatment options (including no treatment) or alternative courses of care. In addition, you have the right to designate someone to make your health care decisions for you in the event you are unable to make these decisions yourself. (These are known as advance directives. For more information, ask your primary care physician.)

12 You have the right to receive the services of the Blue Medicare HMO primary care physician of your choice. Your choice of PCP must be reported to and recorded by the plan. Your PCP is required to provide or arrange care twenty-four (24) hours a day, seven (7) days a week.

17.2
Member responsibilities

1. It is a member's responsibility to select a primary care physician and have all your medical care provided by or arranged by your PCP except for emergency or urgently needed care. Blue Medicare HMO does not cover services which you arrange on your own except for emergencies and urgently needed care or as specified in your Evidence of Coverage.

2. In the event of an emergency, go to the nearest emergency room or call 911 for assistance. We ask that you notify your PCP within forty-eight (48) hours or as soon as possible if you seek emergency care so that he or she can arrange for appropriate follow-up care. If you are out of the service area and require urgently needed care, we request that you, if possible, first telephone your PCP and then seek care from an appropriate local medical facility, according to your PCP's instructions. (Refer to the Evidence of Coverage for details.)

3. It is your responsibility to make monthly plan premium payments for your coverage on or before the first day of the month of coverage, unless your employer/retiree group makes these payments on your behalf. If the premium is not paid on time, we will send you notice of late payment, indicating that your Blue Medicare HMO coverage may be ended according to our Blue Medicare HMO payment guidelines. For more plan payment information, call Customer Service at **1-888-310-4110** or **711** (TDD/TTY).

4. It is your responsibility to inform us of changes in name, address and telephone number, PCP selection, etc.

5. It is your responsibility to pay any required copayments when they are requested of you, such as copayments for office visits.

6. It is your responsibility to pay for any service that is not covered under the plan. This includes services which are excluded from coverage, services obtained from a specialist without referral from your PCP (except in instances where direct access is available) and services obtained from non-plan providers without prior authorization.

7. It is your responsibility to notify the plan if you move out of the Blue Medicare HMO service area. According to Medicare regulations, persons who live outside of the Blue Cross NC Blue Medicare HMO service area are not eligible to continue enrollment in Blue Cross NC.

Continued ▶

8. It is a member's responsibility to keep appointments or follow procedures to avoid missed appointment charges.

9. It is your responsibility to understand how the plan works and follow plan procedures. This includes understanding the referral process to avoid unauthorized, non-covered services.

10. It is your responsibility to supply health care providers information needed to provide adequate care, and to follow treatment advice given by those providing health care services.

11. It is your responsibility to consult with your primary care physician in all matters regarding your health care. This includes contacting your primary care physician for instructions on care after regular office hours, except for emergency or urgently needed care. Inquiries regarding member rights and responsibilities should be directed to the Blue Medicare HMO Customer Service department at **(336) 774-5410** or **1-888-310-4110** or **711** (TDD/TTY), Monday-Friday from 8 a.m. to 6 p.m. ET.

    You may also write to:
    Blue Medicare HMO
    Blue Cross and Blue Shield of North Carolina
    P.O. Box 17509
    Winston-Salem, NC 27116-7509

18

Sanction process

18.1
Grievance procedure / sanction process

There are times when immediate action must be taken to terminate a provider's contract in order to maintain the integrity of the network and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician
- Actions taken by a court of law, regulatory agency or any professional organization which, if successful, would materially impair the provider's ability to carry out the duties under the contract
- Insolvency, bankruptcy or dissolution of a practice

Upon receipt of notification of these actions, the affected provider will be notified of the plan's intent to issue notice of termination from the network. In addition to the circumstances outlined above, other information may be received regarding a network provider which may impact the participation status of that physician. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

18.2
Provider notice of termination for recredentialing

18.2.1
Level I appeal

If the credentialing committee's recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures:

- The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of his or her right to appeal.
- The provider may request a Level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within thirty (30) days from the date or the initial notification of termination
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of his or her right to request a Level II appeal if the decision is unchanged.

18.2.2
Level II appeal

A request for a Level II appeal must be made within fifteen (15) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified time frame will be sent an acknowledgment letter within seven (7) business days of receipt of the request. The acknowledgment letter will contain all pertinent details of the Level II appeal process and notify the practitioner of required next steps and time frames for both parties in the Level II appeal. Blue Cross NC will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the plan, before a hearing officer who is appointed by the plan and is not in direct economic competition with the practitioner involved.

A description of the formal hearing process includes, but is not limited to, the following:

- **Representation:** The practitioner/provider and the plan may be represented by counsel or other person of their choice
- **Court recorder:** Blue Cross NC may arrange for a court recorder to provide a record of the hearing. If Blue Cross NC does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner/provider upon payment of a reasonable charge.
- **Hearing officer's statement of the procedure:** Before evidence or testimony is presented, the hearing officer of the Level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence
- **Presentation of evidence by Blue Cross NC:** The plan may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner/provider or his or her representative will have the opportunity to cross-examine any witness testifying on the plan's behalf.
- **Presentation of evidence by practitioner/provider:** After the plan submits its evidence, the practitioner/provider may present evidence to rebut or explain the situation or events described by the plan. The plan will have the opportunity to cross-examine any witness testifying on the practitioner's/provider's behalf.
- **Examination by the appeals committee:** Throughout the hearing, the appeals committee may question any witness who testifies

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear or otherwise submit required notices, requests and documentation within a timely and adequate manner consistent with the above requirements. In the hearing, the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation of the record and to submit a written statement at the closing of the hearing. Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

Continued ▶

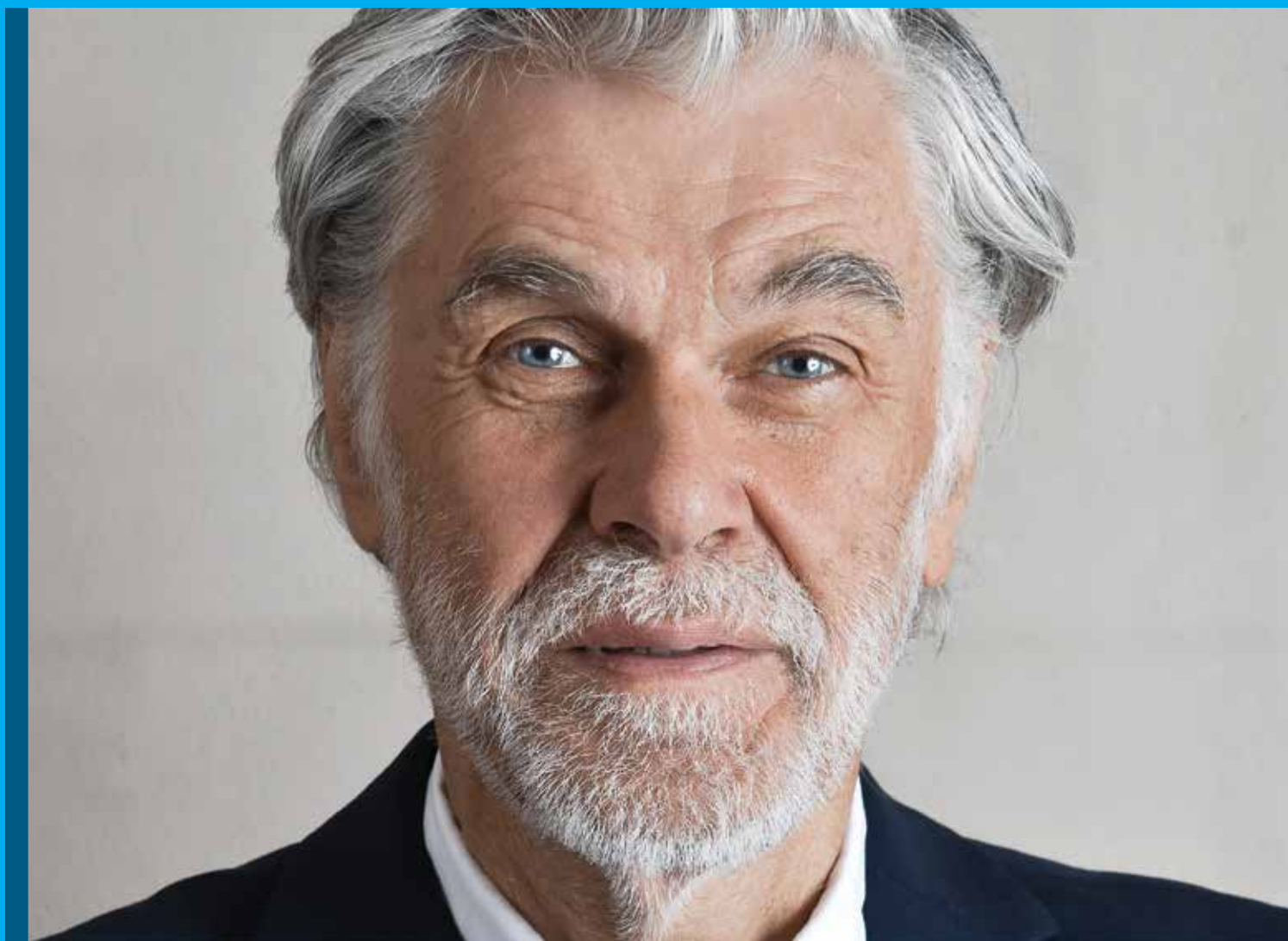
The practitioner will be notified via certified letter within ten (10) business days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) business days of the receipt of the initial notification, or fifteen (15) business days from the receipt of the notification of the Level I appeal decision, the plan will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to provider network operations to proceed with termination from all networks. Communication will be sent from provider network operations to the credentialing manager's administrative assistant to confirm the termination of the provider; copies will be sent to the managers of the credentialing complaint, forwarded to the delegated practitioner's credentialing department for follow-up. Any actions taken by the delegated practitioner as follow-up must be documented and a copy forwarded to Blue Cross NC.

Based on the credentialing committee recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the Blue Cross NC managed care network.

19

Credentialing



19.1
Credentialing/recredentialing

The purpose of credentialing physicians and providers is to exercise reasonable care in the selection and retention of competent, participating providers. The initial credentialing process can take up to sixty (60) days for completion from the date a completed application is received by Blue Cross NC. Blue Cross NC facilitates all credentialing activity for Blue Cross NC. The Blue Cross NC credentialing department deems an application to be complete when all applicable sections of the uniform application are completed accurately, along with all required supporting documentation. This process includes, but is not limited to, verification and/or examination of:

- North Carolina license
- Uniform application to participate as a health care practitioner
- Drug Enforcement Administration (DEA)
- Sufficient comprehensive general liability and professional insurance coverage
- Medicare/Medicaid sanctions
- National Practitioner Databank (NPDB)
- Hospital privileges or letter stating how patients are admitted
- Board certification*
- Other pertinent documentation
- In some instances, a letter of recommendation from the chief of staff or department chair may be required (i.e., if malpractice settlements exceeding $200,000 and/or two [2] or more malpractice settlements)

Initial credentialing requires a signed and dated uniform application to participate as a health care practitioner and the supporting documentation. Full instructions by medical specialty along with a copy of the uniform application can be found on the website ***BlueCrossNC.com/provider-home***.

All documents should be sent to the Blue Cross NC credentialing department for verification and processing. To ensure that our quality standards are consistently maintained, providers are recredentialed every three (3) years.

We require initial credentialing of any practitioner who seeks reinstatement in any of our networks after being out-of-network for more than thirty (30) days.

* For physicians that are not board certified, letters of reference will be required in support of the application.

19.2
Requirements for provider credentialing and provider rights

Blue Cross NC follows a documented process governing contracting and credentialing, does not discriminate against any classes of health care professionals and has policies and procedures which govern the denial, suspension and termination of provider contracts. This includes requirements that providers meet Original Medicare requirements for participation, when applicable. Qualified providers must have a Medicare provider number for participation.

Providers are required to meet and to continue to meet all applicable credentialing standards adopted or utilized by Blue Cross NC during the term of their participation, including the requirement to possess and maintain a current unrestricted medical license, hospital privileges (if applicable) and DEA registration certificate (if applicable). Providers are required to notify Blue Cross NC of subsequent changes in the status of any information relating to provider's professional credentials, including a change in the status of his/her medical license, hospital privileges or DEA registration certificate. Providers are required to participate in and cooperate with Blue Cross NC credentialing and recredentialing processes, and to comply with determinations made pursuant to the same.

19.3
Policy for practitioners pending credentialing

The Blue Cross NC credentialing department must deem a practitioner's credentialing complete and effective on or before providing service to a Blue Cross NC member in order to receive the practitioners contracted reimbursement for member's covered services.

Claims for covered services provided to members by a non-participating practitioner in a participating provider group will be denied unless pre-approved. The Blue Cross NC member will be held harmless, including any copayments, coinsurance and/or deductibles.

19.3.1
Credentialing process

Participating practitioners are encouraged to consider the time required to complete the credentialing process as you add new practitioners to your practices. To assist you in maintaining accessibility in circumstances where your practice and/or the new practitioner are unable to submit the credentialing application in a timely manner, we have created a standard operating procedure that will allow reimbursement for covered services provided by a non-participating practitioner who is in the process of joining a Blue Cross NC participating practice. The following must apply:

- A credentialing application must have been submitted to Blue Cross NC and a determination on such application is pending, and
- The new practitioner must provide covered services to Blue Cross NC members under the direct supervision of a Blue Cross NC-similarly licensed and credentialed practitioner at the practice who signs the medical record related to such treatment and files the claim under his or her current provider number, and
- A statement of supervision form is completed and submitted to the Blue Cross NC provider network (the form may be obtained by the contacting provider network, if needed)

For a copy of the new standard operating procedure outlining the details of this process, or if you have questions, please call Network Management at **1-800-777-1643** for further assistance (see **Chapter 2, Contacting Blue Cross NC and general administration**).

19.4
Credentialing grievance procedure

There are times when Blue Cross NC must take immediate action to terminate a provider's contract in order to maintain the integrity of the network and/or to maintain the availability of quality medical care for members. Reasons justifying immediate terminations are specified in the provider's contract, and may include:

- Loss of license to practice (revocation or suspension)
- Loss of accreditation or liability insurance
- Suspension or termination of admitting or practice privileges of a participating physician
- Actions taken by a court of law, regulatory agency or any professional organization which, if successful, would materially impair the provider's ability to carry out the duties under the contract
- Insolvency, bankruptcy, or dissolution of a practice

Upon receipt of notification of these actions, the affected provider will be notified of Blue Cross NC's intent to terminate them from the network. In addition to the circumstances outlined above, other information may be received regarding a network provider which may impact the participation status of that physician. This would include reports on providers describing serious quality of care deficiencies. Whenever information of this nature is received, it is evaluated through the normal credentialing review process which includes review and recommendation by our credentialing committee.

19.4.1
Provider notice of termination for recredentialing (Level I appeal)

If the credentialing committee's recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures, the provider file is forwarded for an expedient review by law and regulatory affairs.

- If the credentialing committee's recommendation is to terminate a provider from the network for documented quality deficiencies or failure to comply with recredentialing policies and procedures: The provider is formally notified, via certified mail, of our intent to terminate and the specific reason for the proposed action. The provider is informed of their right to appeal.
- The provider may request a Level I appeal by providing additional written documentation which may include further explanation of facts, office or other medical records or other pertinent documentation within thirty (30) days from the date or the initial notification of termination
- Our credentialing committee will review the additional information provided and make a recommendation to either uphold or reverse the original determination. The provider will be notified via certified mail of the decision and of their right to request a Level II appeal if the decision is unchanged.

19.4.2
Level II appeal (formal hearing)

A request for a Level II appeal must be made within fifteen (15) days of the date of the certified letter from the results of the Level I appeal.

Practitioners requesting hearings within the specified time frame will be sent an acknowledgment letter within seven (7) business days of receipt of the request. The acknowledgment letter will contain all pertinent details of the Level II appeal process and notify the practitioner of required next steps and time frames for both parties in the Level II appeal. Blue Cross NC will determine if the hearing will be held before an arbitrator mutually acceptable to the provider and the plan, before a hearing officer who is appointed by the plan and is not in direct economic competition with the practitioner or before a panel of plan-appointed individuals not in direct competition with the practitioner involved.

A description of the formal hearing process includes, but may not be limited to, the following:

- **Representation:** The practitioner/provider and Blue Cross NC may be represented by counsel or other person of their choice.
- **Court recorder:** Blue Cross NC may arrange for a court recorder to provide a record of the hearing. If Blue Cross NC does not arrange for a court recorder, it will arrange for an audio-taped record to be made of the hearing. Copies of this record will be made available to the practitioner/provider upon payment of a reasonable charge.
- **Hearing officer's statement of the procedure:** Before evidence or testimony is present, the hearing officer of the Level II appeals committee will announce the purpose of the hearing and the procedure that will be followed for the presentation of evidence.
- **Presentation of evidence by Blue Cross NC:** Blue Cross NC may present any oral testimony or written evidence it wants the appeals committee to consider. The practitioner/provider or his/her representative will have the opportunity to cross-examine any witness testifying on Blue Cross NC's behalf.
- **Presentation of evidence by practitioner/provider:** After Blue Cross NC submits its evidence, the practitioner/provider may present evidence to rebut or explain the situation or events described by Blue Cross NC. Blue Cross NC will have the opportunity to cross-examine any witness testifying on the practitioner's/provider's behalf.
- **Examination by the appeals committee:** Throughout the hearing, the appeals committee may question any witness who testifies.

Continued ▶

The right to a hearing may be forfeited if the practitioner fails, without good cause, to appear or otherwise submit required notices, requests and documentation within a timely and adequate manner consistent with the above requirements. In the hearing, the practitioner has the right to representation by an attorney or other person of the practitioner's choice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated in preparation of the record and to submit a written statement at the closing of the hearing. Upon completion of the hearing, the practitioner involved has the right to receive a written recommendation of the arbitrator, officer or panel, including a statement of the basis for the recommendation, and to receive a written decision of the health care entity, including a statement of the basis for the decision.

The practitioner will be notified via certified letter within ten (10) business days from the date of the hearing of the final determination.

If a request for reconsideration or a formal hearing is not made by the practitioner within thirty (30) business days of the receipt of the initial notification, or fifteen (15) business days from the receipt of the notification of the Level I appeal decision, Blue Cross NC will assume the provider has forfeited their appeal rights and proceed with the termination as stated in the initial notification letter. A copy of the original notification will be sent to provider network operations to proceed with termination from the network.

Communication will be sent from provider network operations to the credentialing manager's administrative assistant to confirm the termination of the provider, with copies sent to the managers of credentialing, the provider network, marketing and Customer Service.

If a request is made by the practitioner, the termination process will be suspended awaiting the outcome of the reconsideration or formal hearing.

The practitioner may be reinstated if so indicated by the outcome of the hearing. If the decision is unchanged, the plan will proceed with termination.

If Blue Cross NC identifies quality concerns related to a delegated practitioner, the complaint will be forwarded to the delegated practitioner's credentialing department for follow-up. Any actions taken by the delegated practitioner as follow up must be documented and a copy forwarded to Blue Cross NC to be placed in the subscriber file.

Based on the credentialing committee's recommendation to decredential the practitioner, a report is made to the appropriate licensing board. The report details the disciplinary action taken against the practitioner resulting in their loss of privileges to participate in the Blue Cross NC managed care network.

20

Marketing, advertising and brand regulations

Marketing, advertising and brand regulations are the legal rules that must be followed when marketing or advertising a Medicare plan offered by Blue Cross NC or using the Blue Cross NC brand, and must be consistent with applicable law and the terms of the participation agreement with Blue Cross NC.

20.1
Marketing and advertising

The marketing and advertising of MA health plans and Part D prescription drug plans by health care providers is highly regulated by CMS and subject to tight restrictions. As a result, you cannot conduct any marketing or advertising activity related to any Medicare plan offered by Blue Cross NC without prior written approval from Blue Cross NC.

For more information regarding these restrictions, please refer to the Medicare Marketing Guidelines issued by CMS and available through *www.cms.gov*.

20.2
Logo usage

Blue Medicare HMO and Blue Medicare PPO logos are available for use. Please do not alter any elements within the logos.

20.3
Approvals

All marketing pieces (excluding general/operational business letters) that are being developed for dissemination to the public must be reviewed and approved by Blue Cross NC or its designer prior to use.

All Blue Cross NC Medicare materials, after approval by advertising and brand marketing, must be submitted by Blue Cross NC for review and/or approval by CMS, which carries up to a forty-five (45) day mandated allowable approval time.

20.3.1
Sample Blue Medicare HMO and Blue Medicare PPO logos

Blue Medicare HMO℠

Blue Medicare PPO℠

21

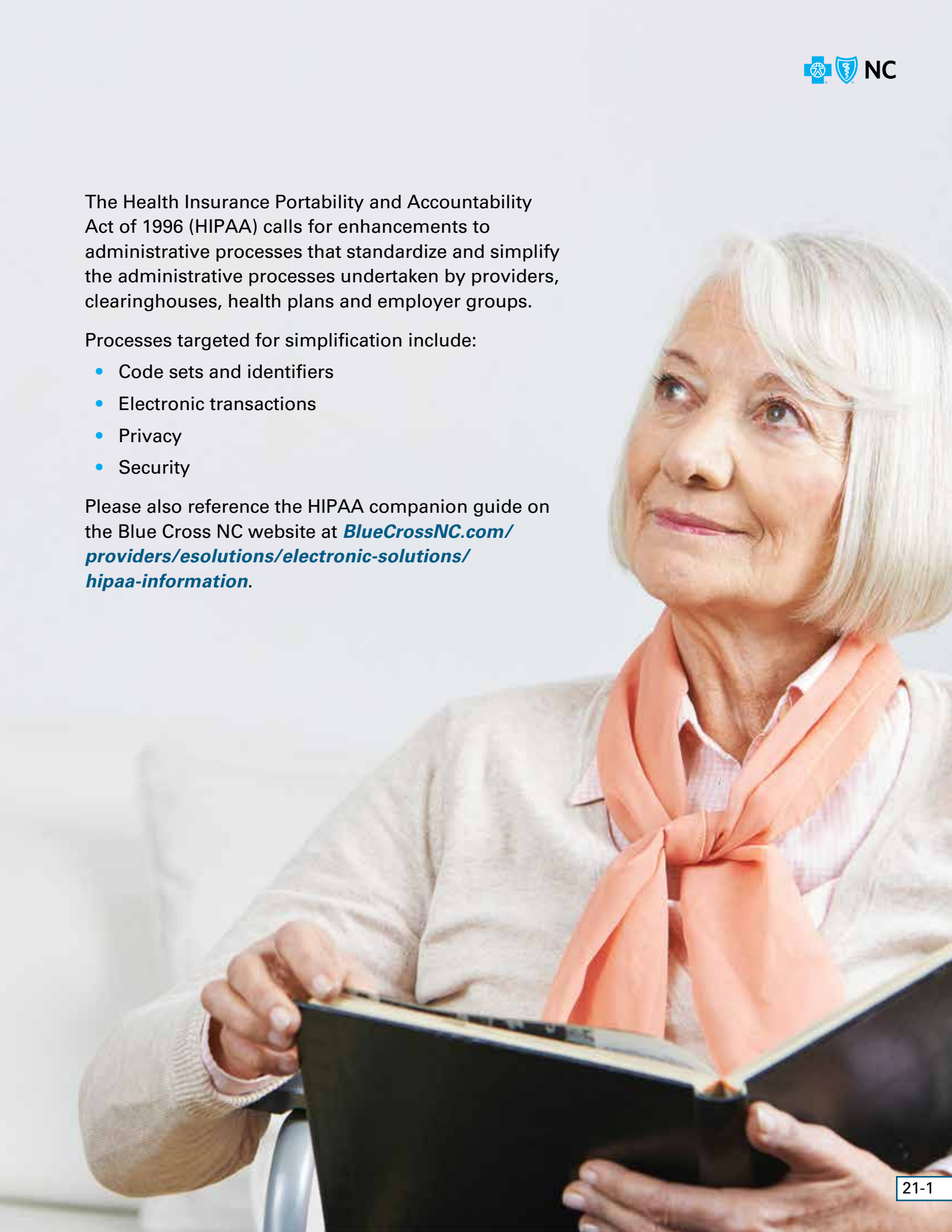
Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) calls for enhancements to administrative processes that standardize and simplify the administrative processes undertaken by providers, clearinghouses, health plans and employer groups.

Processes targeted for simplification include:

- Code sets and identifiers
- Electronic transactions
- Privacy
- Security

Please also reference the HIPAA companion guide on the Blue Cross NC website at ***BlueCrossNC.com/providers/esolutions/electronic-solutions/hipaa-information***.



21.1
Electronic transactions

The administrative simplification provisions mandate of HIPAA requires that all payers, providers and clearinghouses use specified standards when exchanging data electronically. Providers and payers must be able to send and receive transactions in the designated EDI format. Providers will be able to send and receive information from health plans and payers using the following standardized formats:

- Authorizations/referrals
- Claims
- Claims status
- Eligibility
- Remittance

21.2
Code sets and identifiers

Providers should use the following standardized codes to submit claims to health plans:

- CDT (were HCPCS dental codes, but now ADA code, prefixed with "D")
- CPT
- ICD-10-CM
- HCPCS

These common code sets enable a standard process for electronic submission of claims by providers. Blue Cross NC has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper. Code sets must be implemented by the effective date to avoid claims denials.

Continued ▶

Blue Cross NC will maintain taxonomy or specialty codes currently in use and will continue to assign these codes for new providers. The codes are determined during the credentialing and contracting processes. Blue Cross NC only accepts active codes from national code set sources such as ICD-10, CPT and HCPCS as part of our HIPAA compliance measures. As new codes are released, please convert them by their effective date in order to prevent claims from being mailed back for recoding or resubmission. Deleted codes will not be accepted for dates of service after the date the code becomes obsolete. Contact your provider network representative if you have questions.

Common identification numbers will be created for providers, payers and employers, and will be recognized by all entities when performing electronic transactions. Standards for these unique identifiers are currently under development.

21.3
Security

Blue Cross NC maintains a comprehensive security program for safeguarding protected health information in order to meet the requirements of the HIPAA security rule and the North Carolina Customer Information Safeguards Act. The HIPAA security rule requires a covered entity to provide administrative, technical and physical safeguards for protected health information maintained in electronic form. The North Carolina Customer Information Safeguards Act requires North Carolina insurance companies to protect customer information in all formats, whether electronic, paper or oral.

21.4
Privacy

Privacy regulations address the way in which a health plan, provider or health care clearinghouse may use and disclose individually identifiable health information, including information that is received, stored, processed or disclosed by any media, including paper, electronic, fax or voice. Regulations do allow for the sharing of information for treatment, payment and health care operations, including such plan-required functions as quality assurance, utilization review or credentialing, without patient consent. Limited sharing of information may be allowed in instances where national security may be impacted. Please read Blue Cross NC Notice of Privacy Practices for more information about our privacy policies. Our notice may be updated from time to time. Please visit our website, ***BlueCrossNC.com***, for the most current version.

21.5
Additional HIPAA information

- Blue Cross NC has adopted consistent standards, code sets and identifiers for claims submitted electronically and on paper.
- Additional HIPAA information is available through the following organizations:
  - Department of Health and Human Services at *www.hhs.gov*
  - North Carolina Healthcare Information and Communications Alliance at *www.nchica.org*
  - Centers for Medicare and Medicaid Services at *www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/HIPAA-ACA/index.html*, or call **1-410-786-3000**

22

Privacy and confidentiality

At Blue Cross NC, we take very seriously our duty to safeguard the privacy and security of our members Protected Health Information (PHI), as we know you do. Blue Cross NC has developed corporate privacy policies and procedures that address applicable privacy laws and regulations. The highlights of these policies are described below. As contracting providers, we want you to understand how we protect our members' information.

- We protect all personally identifiable information we have about our members and disclose only the minimum necessary information that is legally appropriate. Our members have the right to expect that their PHI will be respected and protected by Blue Cross NC.
- Our privacy and security policies are intended to comply with current state and federal law, and the accreditation standards of the National Committee for Quality Assurance. If these requirements and standards change, we will review and revise our policies, as appropriate. We also may change our policies (as allowed by law) as necessary to serve our members better.
- To make sure that our policies are effective, we have designated a chief privacy official and a chief security officer who are charged with approving and reviewing Blue Cross NC's privacy and security policies and procedures. They are responsible for the oversight, implementation and monitoring of the policies.

22.1
Our fundamental principles for protecting PHI

- We will protect the confidentiality and security of PHI, in all formats, and will not disclose any PHI to any external party except as we describe in our privacy notice or as legally permitted or required
- Each of our employees receives ongoing training on our privacy policies and procedures and must abide by our policies. Only employees who have legitimate business needs to use members' PHI will have access to personal information.
- When we use outside parties (business associates) to perform work for us, as part of our insurance business, we require them to sign an agreement, stating that they will protect members' PHI and will only use it in connection with the work they are doing for us
- We communicate our practices to our members, through our privacy notice, other communications and during the enrollment process they follow when becoming a Blue Cross NC member
- We will disclose and use PHI only where:
  - Required or permitted by law
  - We obtain the member's authorization
- We will respect and honor our members' rights to inspect and copy their PHI, request an amendment or correction to their PHI, request a restriction on use and disclosure of PHI, request confidential communications, file a privacy complaint, request an accounting of disclosures and request a copy of our Notice of Privacy Practices

Please read Blue Cross NC's Notice of Privacy Practices for more information about our privacy policies. Our notice may be updated from time to time. Please visit our website, ***BlueCrossNC.com***, for the most current version.

22.2
Privacy regarding services or items paid out-of-pocket

If a member pays the total cost of medical services and requests that a provider keep the information confidential, the provider must abide by the member's wishes and not submit a claim to Blue Cross NC for the specific services covered by the member. Under current regulations, you may bill, charge, seek compensation or remuneration or collection from the member for services or supplies that you provided to a member if the member requests that you not disclose personal health information to us, and provided the member has paid out-of-pocket in full for such services or supplies. Additionally, you are not permitted to (i) submit claims related to, or (ii) bill, charge, seek compensation or remuneration or reimbursement or collection from us for services or supplies that you have provided to a member for which that member paid out-of-pocket.

23

Medicare Advantage and Part D Compliance

23.1
Medicare Advantage and Part D compliance for participating providers and their business affiliates

Blue Cross NC is honored to support the CMS to maintain a compliance program that includes provisions to protect our members, providers and business partners from fraud, waste and abuse (FWA). CMS advises that the seven (7) basic elements of the compliance program include:

- Maintain a compliance program that includes provisions to protect our members, providers and business partners from fraud, waste and abuse
- Instituting high-level oversight, led by a compliance officer
- Providing effective training and education about Medicare program requirements
- Providing effective and accessible lines of communication between the compliance officer, employees, and First Tier, Downstream and Related Entities (FDRs)
- Ensuring that disciplinary standards are well-publicized
- Performing routine monitoring, auditing and identification of compliance risks
- Establishing procedures for prompt response to compliance issues

Blue Cross NC ensures that these elements are met in the following ways:

- Maintain an electronic library of policies, including a written ethics and compliance program
- Blue Cross NC has a compliance officer and a formal committee structure to provide oversight responsibilities for compliance
- Blue Cross NC provides annual training to its employees, its board of trustees, and sales agents on general compliance and FWA. Providers, vendors, and other business partners who have met the FWA training through enrollment in Parts A or B of the Medicare program, or through accreditation as a supplier of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), are deemed to have met the FWA training and education requirements for Blue Cross NC.
- Blue Cross NC has a dedicated SIU that is focused on the organization's overall mission to improve the health and well-being of our customers and communities. One of the ways we do that is by working hard to protect our members, providers and business partners from health care FWA. All Blue Cross NC employees share in this critical responsibility.

Continued ▶

- Blue Cross NC offers several options for employees, producers and subcontractors to report issues or ask questions, either directly or via anonymous hotlines, or related online reporting tools. If there is suspected FWA, please contact the **Special Investigations Unit (SIU)** at **1-800-324-4963**. If there are concerns about the actions of a Blue Cross NC employee, please contact the Blue Cross NC Ethics Hotline at **1-888-486-1554**.
- Consequences for Blue Cross NC employees who violate the Blue Cross NC Code of Conduct or the FWA policy are clearly communicated through our internal Code of Conduct policy, and through annual employee-required training courses
- Blue Cross NC monitors hotline reports for trends, analyzes claims data to identify potential fraud, and reviews key CMS compliance metrics. Blue Cross NC also performs risk assessments, executes audit plans and conducts subcontractor oversight.
- Blue Cross NC has written processes in place to investigate issues, track the identified issues through remediation and report matters to government entities when necessary

Due to Blue Cross NC's relationship with CMS, Blue Medicare-participating providers should be aware of several key federal rules:

- **Anti-Kickback Statute –** This statute imposes criminal penalties for individuals or entities who knowingly and willfully offer, pay, solicit or receive remuneration to induce or reward business reimbursement in federal health care programs
- **False Claims Act –** This act imposes liability on any person of an organization who submits a claim to the federal government that is known or should be known to be false
- **Excluded Entity Provision of Social Security Act –** Medicare Part C and Part D contractors are prohibited from employing or contracting with an individual or entity who is excluded from participation in federal health care programs

24

Forms

The following form is referenced in the preceding sections of this guide. We have included copies of the following form for you to copy and use at your convenience.

- **Level I Provider Appeal Form for Blue Medicare HMO and Blue Medicare PPO**

Note: Pharmacy forms, including drug-specific fax forms, are available for download via our website or by contacting the Provider Line at **1-888-296-9790**. Some forms are updated at least once annually.

Always verify you are using the most current version by visiting us on the web at ***BlueCrossNC.com/content/medicare/member/policies/approval.htm***.

Sample Level I Provider Appeal Form for Blue Medicare HMO and Blue Medicare PPO

LEVEL ONE PROVIDER APPEAL FORM FOR BLUE MEDICARE HMO[SM] AND BLUE MEDICARE PPO[SM]

BlueCross BlueShield of North Carolina

Blue Cross and Blue Shield of North Carolina is an independent licensee of the Blue Cross and Blue Shield Association

Section I: Patient Information

Alpha Prefix (Copy from the member's BCBSNC identification card) **Patient Date of Birth**

Subscriber Number (Copy from the member's BCBSNC identification card)

Patient Name (First, middle initial, last)

Section II: Physician Information

Requesting Physician (Print first, last name) **Requesting Physicians Signature** (Signature & date)

Fax - - **Phone** - -

Physician NPI Number

Physician Mailing Address (Street or P.O. Box, City, State & Zip Code)

Section III: Appeal Information

Date of Service - -

Date of Notification of Payment - -

CPT Codes -

-

Diagnosis Codes .

.

Claim Identification Number

APPEAL REASON (select one reason only)

MEDICAL NECESSITY:

- ☐ Cosmetic
- ☐ Experimental/ Investigational
- ☐ No authorization for inpatient admission
- ☐ Not Medically Necessary

BILLING/CODING:

- ☐ Coding/ Bundling or Fee Denials
- ☐ Global Period Denial
- ☐ Re-bundling
- ☐ Services Not Eligible for Separate Reimbursement

OTHER:

- ☐ Non-Contracting Provider Payment Disputes

FAX NUMBER FOR POST SERVICE APPEALS – (919) 287-8815

Comments (If additional space is needed, please use the back of this form)

☐ **Records Attached**

This form is intended for use only when requesting a review for post service appeal requests for Medicare Advantage membership. Completed forms accompanied by any supporting documentation should be sent to: **Provider Appeals Unit, *Blue Medicare HMO[SM] and Blue Medicare PPO[SM], P.O. Box 17509, Winston-Salem, NC 27116-7509 or Fax: (919)287-8815.***

Please refer to the Blue Medicare HMO[SM] and Blue Medicare PPO[SM] provider manual located on the BCBSNC Web site for providers at ***www.bcbsnc.com/content/providers/blue-medicare-providers/resources-and-forms/index.htm*** or contact your local Network Management field office for assistance with the claims inquiry process.

25

Healthy Blue + Medicare Dual-Eligible Special Needs Plan

25.1
Introduction

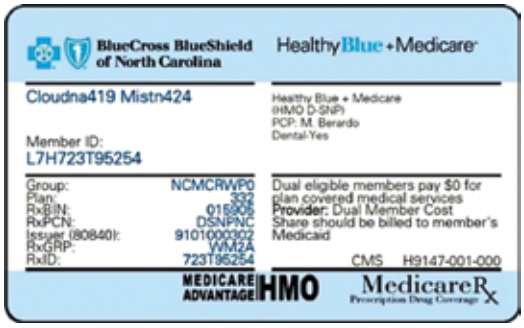
Healthy Blue + Medicare (HMO D-SNP) is offered pursuant to a contract between CMS and Blue Cross and Blue Shield of North Carolina Senior Health, a wholly-owned subsidiary of Blue Cross NC. Healthy Blue + Medicare is an included MA plan for all Blue Cross NC Medicare Provider Agreements, and its members are served by the same network that serves all other MA plans offered by Blue Cross NC. The amounts due, bundling edits, policies and procedures may differ based on the specific product as a result of different benefit designs and claims adjudication methodologies. Claims will be paid consistent with current contract provisions, and Blue Cross NC will use its best efforts to apply bundling logic that is consistent with industry AMA HCPCS (Level I and Level II) or CMS CCI standards in effect at the time of the date of service.

To view the member benefits guide for Healthy Blue + Medicare, visit ***medicare.BlueCrossNC.com/medicare.***

Continued ▶

Contacts				
Point of Contact	**Telephone**	**Fax**	**Address**	**Hours of Operation**
Customer Care (Medical & Drug)	**1-833-713-1078**	**1-855-358-1226**	Healthy Blue + Medicare Customer Service P.O. Box 62947 Virginia Beach, VA 23466-2947	8 a.m. to 8 p.m. ET seven days per week, except Thanksgiving & Christmas
Grievances and Appeals (Medical & Drug)	**1-833-713-1078**	**1-888-458-1406**	Medicare Complaints, Appeals, Grievances 4361 Irwin Simpson Rd. Mail Stop: OH0205-A537 Mason, OH 45040	8 a.m. to 8 p.m. ET seven days per week, except Thanksgiving & Christmas
Provider Services (Medical & Drug)	**1-844-895-8160**	**1-877-799-4129**	Healthy Blue + Medicare P.O. Box 60007 Los Angeles, CA 90060-0008	8 a.m. to 8 p.m. ET seven days per week, except Thanksgiving & Christmas
Case Management (Medical & Drug)	**1-866-611-4287**	**1-855-443-7821**	Healthy Blue + Medicare 3350 Peachtree Rd. NE Mail Stop: GAG006-0012 Atlanta, GA 30326	8 a.m. to 5 p.m. ET M-F, except holidays

25.2
Sample ID card



25.3
Vision care

Providers in the Community Eye Care Blue Medicare network will be in-network for the Healthy Blue + Medicare medical vision benefits. Routine vision services are not covered through the Healthy Blue + Medicare medical vision network. All medical claims for vision care for Healthy Blue + Medicare members should be submitted to the address on the back of the member's ID card.

Please refer to the member benefits guide for routine vision care on the *More Healthy Benefits* page.

25.4
Diabetic supplies

Members requiring diabetic test strips (diabetic supplies) will only be covered through their pharmacy network. Test strips are limited to two manufacturers: Ascensia and LifeScan. These supplies will not be covered as in-network when supplied by durable medical equipment providers. This applies to our Medicare Advantage HMO and PPO benefits.

25.5
Provider training and attestation requirements

CMS requires all contracted providers and staff to receive basic training about the D-SNP Model of Care. This training and completion of an attestation are required for new providers and annually thereafter. Additional information regarding training will be provided at a later date.

25.6
Managed care plan enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A and B and continue paying Part B premiums
- Live in the plan's service area

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7 each year, with a January 1 plan effective date.

25.7
Medicare Dual-Eligible Special Needs plans

Dual-eligible special needs plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Health Plan under Title XIX (Medicaid). D-SNPs offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. The following Medicaid eligibility categories are presently eligible for Healthy Blue + Medicare:

- Qualified Medicare beneficiary without other Medicaid (QMB only)
- QMB+
- Specified low-income Medicare beneficiary with full Medicaid SLMB+
- Other full benefit dual-eligible (FBDE)

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

- Medicare zero cost sharing D-SNPs
- Medicare non-zero cost sharing D-SNPs

25.8
Cost sharing and billing

Cost sharing responsibility for special needs plan members

Members that are dually-eligible for Medicare and for full Medicaid coverage of their Medicare Part A and Part B premiums and other cost sharing (such as deductibles, coinsurance and copayments) through a Medicare Savings Program, are protected from liability for payment of Medicare premiums, deductible, coinsurance and copayment amounts. Some Medicare Savings Programs cover some but not all of the premiums and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the Qualified Medicare Beneficiary (QMB) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually-eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services — even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a fully-eligible dual member or a QMB member are in violation of federal law and are subject to sanctions. Providers also may not accept dually-eligible beneficiaries as 'private pay' in order to bill the patient directly, and providers identified as continuing to bill dually-eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Blue Cross NC and/or its designee processes the claim for reimbursement when there is an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its SNP. The state retains responsibility for cost sharing when Blue Cross NC and/or its designee does not have an arrangement with the state Medicaid agency.

Continued ▶

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare non-participating provider (hereinafter referred to as a non-participating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the CMS-5010 claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of the MA plan, non-contracting and Original Medicare, non-participating providers are listed below by type of provider.

Contracted provider

There is no balance billing paid by either the plan or the enrollee.

Non-contracting, Original Medicare, participating provider

There is no balance billing paid by either the plan or the enrollee.

Non-contracting, non-(Medicare)-participating provider

The Medicare Advantage Organization (MAO) owes the non-contracting, non-participating (non-par) provider the difference between the members' cost sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost sharing
- MA-plan, non-contracting, non-participating DME supplier. The MAO owes the non-contracting, non-participating (non-par) DME supplier the difference between the member's cost sharing and the DME supplier's bill; the enrollee only pays plan allowed cost sharing, which equals:
  - The copay amount, if the MAO uses a copay for its cost sharing; or
  - The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in the *MA Payment Guide for Out-of-Network Payments*, at ***www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.***

MA plans must clearly communicate to enrollees through the Evidence of Coverage (EOC) and Summary of Benefits (SOB) their cost sharing obligations as well as their lack of obligation to pay more than the allowed plan cost sharing as described above.

If you are a non-contracting, non-participating (Medicare) provider who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Loss of Medicaid coverage for Special Needs Plan members

Blue Cross NC D-SNP (Dual-Eligible Special Needs Plan) members are dual-eligible beneficiaries with both Medicare and Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB+). Medicare members who do not receive full Medicare cost share assistance under Medicaid may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended length of services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services.

25.9
Claims filing

All claims for Healthy Blue + Medicare members are required to be filed through Availity. We have provided a claims filing tutorial should you need assistance on the provider's home page at ***BlueCrossNC.com***.

To ensure that you do not experience any claim delays, please do not file any claims through Blue *e* or mail any claims to Blue Cross NC. The Availity portal is your exclusive secure website that will allow you to access many of your HMO D-SNP online tools and resources. The use of Availity for these functions provides you with access to real-time information and instant responses in a consistent format.

Please visit ***BlueCrossNC.com/providers/blue-medicare-providers/healthy-blue-medicare*** for additional information.

25.10
Model of care

We have a model of care program in place for members of our SNPs. Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified. Goals are defined in our model of care and are specific to the population. The SNP model of care is designed to improve the care of our members in all of the following areas:

   - Improving access and affordability of the health care needs of the population
   - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), individualized care plan (ICP) and interdisciplinary care team (ICT)
   - Enhanced care transitions across all health care settings and providers
   - Ensuring appropriate utilization of services for preventive health and chronic conditions

2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an individualized interdisciplinary care team which may include any of the following members: Nurses, physicians, social workers, pharmacists, our member, behavioral health specialists or other participants as determined by the member.

Continued ▶

3. We work to complete a health risk assessment (HRA) on each member. For new members, the goal is to complete the initial HRA within 90 days of eligibility and then annually before the next anniversary of the last HRA. We perform outreach in multiple ways to attempt to reach all our members. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental topics and serves as the basis for the member's ICP. Providers have access to the HRA results and the ICP through the provider portal.

4. Based on the results of the HRA, an ICP will be developed by the case manager working directly with the member and the ICT to address identified needs. The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual-eligible special needs members. The member's care plan will coordinate with and support your medical plan of care.

5. An ICT is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.

6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.

7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, our members and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, HRA results and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments or recommendations about the care plan or the needs that have been identified during the care planning process. You may reach your patients' care

Continued ▶

team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.

8 We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.

9 Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management program and include any of the following measures:

- HEDIS® — used to measure performance on dimensions of care and service
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey
- Health Outcomes Survey (HOS) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status; while not limited to SNP member responses, we use these results to assist us in the population assessment

Continued ▶

- CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
- Medication therapy measurement measures
- Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation or on our provider portal.

Annual program evaluation

We conduct an annual evaluation of the model of care to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we review our program to identify any issues. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that are not trending toward our benchmarks. We compare our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets, we are meeting or exceeding expectations in many areas. We are also showing an upward trend when we compare our year-over-year results. We continue to work on ways to improve our outreach to our members and improve our completion rates for the health risk assessments, individualized care plans and interdisciplinary care teams for each of our special needs plan members. We manage use of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and post discharge management which continue to improve in most markets. Preventive care goals are established for our programs and managed as a part of HEDIS. Multiple interventions are put in place to improve the HEDIS and STAR measures.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

Note: HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

25.11
Model of care attestation

Annually, a representative from each provider's practice/group and/or facility must attest to completing the SNPs and model of care overview. After completing the training, an attestation form must be completed by the representative. All attestations must be returned to Blue Cross NC either electronically or via fax. This will move care transition protocols and management down and renumber them.

25.12
Care transition protocols and management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and include changes in a member's level of care. Examples of transitions include transitions to and from: Acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an

Continued ▶

environment where the member and the provider are cooperatively involved in ongoing health care management with the goal of providing access to high-quality, cost-effective medical care.

Personnel responsible for coordinating care transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual populations, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are protocols when managing transitions:

- Participate in the interdisciplinary care team meetings
- Notify the member in advance of a planned transition
- Provide documentation to the provider or facility about the member to assist in providing continuity of care
- Communicate and follow-up with the member about the transition process
- Communicate health status and plan of care to the member
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another
- Provide relevant patient history to the receiving provider
- Forward pertinent diagnostic results to treating providers
- Communicate any test results and the treatment plan back to the referring provider

Continued ▶

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member's care needs as identified during case management or model of care activities
- Assist the member in making appointments
- Coordinate between Medicaid and Medicare benefits
- Perform medication reconciliation
- Arrange transportation
- Refer the member to external or internal programs
- Coordinate care with behavioral health services
- Assist with arranging DME and home health services
- Coordinate and facilitate transitions to the appropriate level of care
- Provide the member with disease-specific education and self-management techniques
- Contact high-risk members post-discharge to reduce unnecessary readmissions
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition

25.13
Participating provider responsibilities in the member appeals process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an Appointment of Representative Form may be required. The Appointment of Representative Form can be found online and downloaded at ***www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207***.
- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function
- The CMS guidelines should be utilized when requesting services and initiating the appeals process

25.14
Appeal time frames

- Members or their authorized representatives have sixty (60) days from the date of the initial adverse determination to file an appeal. The sixty (60) day filing deadline may be extended where good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug must be resolved within thirty (30) calendar days from the date the request was received, unless it is in the member's interest to extend the time frame
  - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals are resolved within seventy-two (72) hours, unless it is in the member's interest to extend this time period.
  - A standard pre-service appeal for the coverage of a Part B drug must be resolved in seven (7) days from the date the request was received. Part B drug appeals time frames cannot be extended.
- Post-service payment appeals must be resolved within sixty (60) calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
  - Part D expedited pre-service appeals must be resolved within seventy-two (72) hours from receipt. Part D standard pre-service appeals must be resolved within seven (7) days from the date the request was received.
  - Part D payment appeals must be resolved within fourteen (14) days from the date the request was received
  - Part D appeals time frames cannot be extended

25.15
Further appeal rights

If Blue Cross NC is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Blue Cross NC will forward the appeal to an Independent Review Entity (IRE) contracted with the federal government. The IRE will review the appeal and make a decision:
  - Within twenty-four (24) hours of the adverse decision, if expedited
  - Within thirty (30) days if the appeal is related to authorization for health care that is not a Part B drug
  - Within seven (7) days if the appeal is related to authorization of a Part B drug
  - Within sixty (60) days if the appeal involves reimbursement for care (or thirty [30] days for integrated DSNP plans with unified grievance and appeal procedures)
  - Part D prescription drug appeals are not forwarded to the IRE by Blue Cross NC but may be requested by the member or representative; information will be provided on this process during the Blue Cross NC Medicare member appeals process
- If the IRE issues an adverse decision (not in the member's favor) 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. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

Continued ▶

Hospital discharge appeals and QIO review process

Hospital discharges are subject to an expedited member appeal process. CMS has determined that MA members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, the member must request an immediate review by the QIO. The member or their authorized representative, attorney or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight on the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records and any other information it needs to make a decision. While the member remains in the hospital, Blue Cross NC continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

25.16
Member grievances

A member grievance is the type of complaint a member makes regarding any other type of problem with Blue Cross NC or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Blue Cross NC must accept grievances from members orally or in writing within sixty (60) days of the event.* Blue Cross NC must make a decision and respond to the grievance within thirty (30) days. A member can request an expedited grievance, in which case Blue Cross NC has twenty-four (24) hours to respond. An expedited grievance can only be initiated if Blue Cross NC refuses to grant the member an expedited organization/coverage determination, or an expedited reconsideration/redetermination, or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). Blue Cross NC can request up to fourteen (14) additional days to respond to a grievance if it is in the member's best interest.

* **Note:** Some plans may not limit the time in which a member grievance is filed (for example, certain integrated DSNP plans and MMPs). These plans allow the member to file a grievance at any time.

26

Glossary of terms

A

Additional benefits
Health care services not covered by Medicare.

Agreement
The agreement between Blue Cross NC and members that includes Evidence of Coverage, riders, amendments and attachments.

Annual Election Period (AEP), enrollment period
The AEP is the period of October 15 through December 7 during which Medicare beneficiaries may elect enrollment in an MA plan for the following year. This period will also be the period during which an enrollee in an MA plan may elect to return to Original Medicare or elect a different MA plan. In addition to the AEP, Blue Cross NC will accept applications during a continuous enrollment period each month for new Medicare beneficiaries and those with eligibility for a Special Election Period unless it provides notice to CMS and the public that it has changed its continuous open enrollment policy.

B

Basic benefits
All health care services that are covered under the Medicare Part A and Part B programs (except hospice services), and additional services that we use Medicare funds to cover.

Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
An independent contractor paid by CMS to review medical necessity, appropriateness and quality of medical care and services provided to Medicare beneficiaries. Upon request, the BFCC-QIO also reviews hospital discharges for appropriateness and quality of care complaints.

Benefit period
A spell of illness is a period of consecutive days that begins with the first day (not included in a previous spell of illness) on which a patient is furnished inpatient hospital or extended care services and the spell of illness ends with the close of a period of sixty (60) consecutive days during which the patient was neither an inpatient of a hospital nor an inpatient of a skilled nursing facility. To determine the sixty (60) consecutive day period, begin counting with the day on which the individual was discharged. Spell of illness also applies to home health.

C

Calendar year
A twelve (12) month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Center for Health Dispute Resolution (CHDR)
An independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Medicare HMO and Blue Medicare PPO.

CMS
Refers to the Centers for Medicare and Medicaid Services. It is the agency responsible for administering Medicare and federal participation in Medicaid. It also oversees the provision of health care benefits to Medicare beneficiaries by CMS-approved Medicare Advantage organizations.

Coinsurance
A fixed percentage of the recognized charges for a covered service that a member is required to pay to a provider.

Coordination of Benefits (COB)
Means those provisions which Blue Cross NC uses to coordinate benefits for costs incurred due to an incident of sickness or accident which may also be covered by another insurer, group service plan or group health care plan. These provisions are also known as Medicare Secondary Payer (MSP).

Copayment
Means a fixed dollar amount of payment made by a member to a provider. Copayments must be made at the time services and/or supplies are received. Specific cost share amounts can be found in the member's Evidence of Coverage for their plan.

Custodial care
Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets and taking medication. Custodial care is not covered by Blue Cross NC or Original Medicare unless provided in conjunction with Blue Cross NC approved skilled nursing care.

D

Designated provider/authorized provider

Refers to the provider appointed by Blue Cross NC to provide a specific covered service.

Disenrollment

Means the process of ending or terminating membership in Blue Cross NC.

Drugs

Defined as inpatient medications which require a physician's order or outpatient medications which require a prescription. To be covered, a drug must be covered by Medicare and Blue Cross NC using Medicare coverage guidelines.

Durable Medical Equipment (DME)

Means equipment which is: **(1)** designed and intended for repeated use; and/or **(2)** primarily and customarily used to serve a medical purpose; and **(3)** generally not useful to a person in the absence of disease or injury; and **(4)** appropriate for use in the home. Must meet Medicare guidelines for coverage. Braces and prosthetic devices as defined by Medicare are considered part of the DME benefit.

E

Emergency medical condition

A medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in placing the health of an individual or unborn child in serious jeopardy, serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

Emergency services

Covered inpatient or outpatient services that are **(1)** furnished by a provider qualified to furnish emergency services; and **(2)** needed to evaluate or stabilize an emergency medical condition.

Evidence of coverage (EOC)

The document which describes services and supplies provided to a member. Refers to this document, which explains covered services and defines our obligations and your rights and responsibilities as a member of Blue Cross NC.

Continued ▶

Exclusions
Items/services which are not covered under this Evidence of Coverage.

Experimental and/or investigational
Refers to medical, surgical, psychiatric and other health care services, supplies, treatments, procedures, drug therapies or devices that are determined by Blue Cross NC to be either: **(1)** not generally accepted or endorsed by health care professionals in the general medical community as safe and effective in treating the condition, illness or diagnosis for which their use is proposed; or **(2)** not proven by scientific evidence to be safe and effective in treating the condition, illness or diagnosis for which their use is proposed.

G

Grievance and appeal procedure
The method of resolving member complaints, grievances and appeals.

H

Home health services
Shall mean skilled nursing care or therapeutic services provided by an agency or organization licensed by the state and operating within the scope of its license. For home health services to be a covered benefit, the member must be homebound (confined to home), under a plan of treatment established and periodically reviewed and approved by a physician and in need of intermittent skilled nursing services, physical therapy or speech therapy. (**Please Note:** Custodial care is not included under this definition.)

Hospice
An organization or agency, certified by Medicare, that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

I

Indemnification, beneficiary financial protection

Ensures that the member can not be held financially liable for payment of fees which are the legal responsibility of Blue Cross NC. This would include the services of Blue Cross NC contracting providers as well as non-contracting providers.

L

Lifetime

Means any period of time throughout the member's life when member is covered by Blue Cross NC.

Lock in

Means that as a member, all of your necessary health care treatment and services (other than an emergency medical condition, urgently needed services, out of area renal dialysis and required post-stabilization care) must be provided by a contracting provider or authorized by Blue Cross NC.

M

MA

Refers to the term Medicare Advantage organization, formerly Medicare+Choice. Provisions of the program are defined under Medicare Part C.

Medically necessary

Refers to the medical need for diagnosis and care of treatment of a member. Medically necessary supplies and services are supplies and services that are: **(1)** provided for the diagnosis, treatment, cure or relief of a condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes; **(2)** necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms; **(3)** within generally accepted standards of medical care in the community; and **(4)** not solely for the convenience of the member, member's family or the provider. Plan may compare the cost-effectiveness of the alternative services or supplies when determining which of the services or supplies will be covered. Blue Cross NC shall have the full power and discretionary authority to determine whether any care, service or treatment is medically necessary, subject only to a member's right of grievance and appeal defined in the Evidence of Coverage, and Blue Cross NC may compare the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Continued ▶

Medicare Advantage organization

A public or private entity organized and licensed by the state as a risk-bearing entity that is certified by CMS as meeting MA requirements. MA organizations can offer one (1) or more MA plans. Blue Cross NC is a Medicare Advantage organization.

There are three (3) types of Managed Care Organizations (MCO): **(1)** coordinated care plans, like Blue Cross NC, which include a network of providers that are under contract or arrangement with the MA to deliver the services approved by CMS; **(2)** Medicare Advantage Medical Savings Accounts (MSAs); and **(3)** Medicare Advantage private fee-for-service plans.

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 B

Supplementary medical insurance that is optional and requires a monthly premium. This a called the Medicare Part B 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 C

A federal program with a primary goal of providing Medicare beneficiaries with a range of health plan choices through which to obtain their Medicare benefits. CMS contracts with private organizations offering a variety of private health plan options for Medicare beneficiaries, including both traditional managed care plans such as HMOs, and new options that were not previously authorized. Originally known as the Medicare+Choice program, it was renamed by CMS and is now known as the Medicare Advantage program.

Medicare Part D

Effective January 1, 2006, this is a new federal program offering prescription drug benefits to Medicare beneficiaries. This benefit can be offered by private organizations including pharmacies and private health plans.

Medicare, Original Medicare

The federal government health insurance program established by Title XVIII of the Social Security Act.

Member

Refers to the Medicare beneficiary entitled to receive health care services under the terms of this Blue Cross NC Evidence of Coverage, who has voluntarily elected to enroll and whose enrollment in the Blue Cross NC Medicare Advantage plan has been confirmed by CMS.

N

National coverage decisions

Refer to coverage issues mandated by Medicare.

Non-contracting medical provider or facility

Any professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the state or Medicare to deliver or furnish health care services; and which is neither employed, owned, operated by nor under contract with Blue Cross NC to deliver covered services. (These providers differ from contracting providers who affiliate with Blue Cross NC to provide care for plan members.)

Non-covered services

Those medical services and supplies described in the member's Evidence of Coverage as not covered by Blue Cross NC.

O

Optional supplemental benefits

Those benefits not covered by Medicare which are purchased for an additional plan premium at the option of the Medicare beneficiary. The existence or availability of optional supplemental benefits may vary by county. Blue Cross NC does not offer any optional supplemental benefits.

Out-of-area service

Refers to those services and supplies provided outside the Blue Medicare HMO or Blue Medicare PPO service area.

P

Post-service appeal
Shall have the meaning assigned to that term in Section 7.11(c)(ii)(A) of the Thomas/Love Settlement Agreement.

Post-stabilization care
Covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition, or to improve or resolve the enrollee's condition, as specified by CMS.

Primary Care Physician (PCP)
A contracting physician selected by a Blue Cross NC member who is responsible for providing or arranging for medical and hospital services covered under this Evidence of Coverage.
Note: A person who has acquired the requisite qualifications for licensure and is licensed in the practice of medicine.

Prior authorization
A system whereby a provider must receive approval from Blue Cross NC before the member is eligible to receive coverage for certain health care services.

Provider
A hospital, non-hospital facility, doctor, or other provider accredited, licensed or certified where required in the state of practice, performing within the scope of license or certification.

R

Recognized charge(s)
Means the charge for a covered service which is the lower of: **(1)** the provider's usual charge for furnishing it; or **(2)** the charge Blue Cross NC determines to be the recognized charge made for that service or supply. In determining the recognized charge for a service or supply that is unusual, not often provided in the area or provided by only a small number of providers in the area, Blue Cross NC may take into account factors such as: The complexity; degree of skill needed; type or specialty of the provider; range of services provided by a facility; and the prevailing charge in other areas.

S

Service area
The geographic area approved by CMS within which an eligible Medicare beneficiary may enroll in a particular Medicare Advantage plan offered by Blue Cross NC. A listing of the approved service area can be found in **Chapter 4** of this manual.

Continued ▶

Skilled nursing facility
A facility certified by Medicare which provides inpatient skilled nursing care, rehabilitation services or other related health services. The term skilled nursing facility 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.

Spell of illness
See benefit period.

Supplemental benefits
Those benefits not covered by Medicare for which the MA organization may charge the enrollee an additional plan premium. These benefits are offered as an option for the Medicare enrollee to select (optional supplemental benefits) or as a requirement for enrollment (mandatory supplemental benefits). Blue Cross NC does not offer any optional supplement benefits.

T

Termination date
The date that coverage no longer is effective, (i.e., at 12:00 midnight on the last day coverage is effective). Also referred to as disenrollment date. Coverage typically ends on the last day of the month.

U

Urgent care facility
A health care facility whose primary purpose is the provision of immediate, short-term medical care for non-life-threatening urgently needed services.

Urgently needed services
Means covered services, that are not emergency services, provided when you are temporarily absent from the Blue Cross NC service area (or, under unusual and extraordinary circumstances, provided when you are in the service area but your PCP is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required: **(1)** as a result of an unforeseen illness, injury or condition; and **(2)** it is not reasonable given the circumstances to obtain the services through your PCP.

The Blue Book℠
BlueMedicare HMO℠
BlueMedicare PPO℠

Contact **Blue Cross NC**

Phone: **1-800-400-8745** (TTY: 711)
Hours: 7 days a week, 8 a.m. – 8 p.m. ET
Online: ***BlueCrossNC.com/Medicare***
Centers: ***BlueCrossNC.com/Centers***

Or contact your Blue Cross NC **Authorized Agent.**