BLUE ADVANTAGE

Provider Manual

Blue Advantage®
A Medicare Approved PPO

PRV20221-2204

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Introduction

The Balanced Budget Act of 1997 established a Medicare program called the Medicare+Choice (M+C), now known as Medicare Advantage. This action significantly expanded the healthcare options available to Medicare beneficiaries.

Blue Cross and Blue Shield of Alabama contracted with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare-covered services to beneficiaries through a Medicare Advantage Plan. This plan, Blue Advantage, is a Medicare-approved Preferred Provider Organization (PPO) Plan option for beneficiaries. Blue Advantage is offered to beneficiaries residing in the state of Alabama. Blue Advantage provides the same or higher level of benefits that a beneficiary is entitled to if covered by Medicare.

Blue Advantage works much like the traditional Medicare program. Beneficiaries are free to go to any physician or hospital they choose as long as the provider is an eligible participating Medicare provider and has agreed to participate with the Blue Advantage plan. Agreements for participation are extended to all appropriate providers in order to maintain a sufficient network for beneficiaries. Included is specialty care and direct access to participating providers that specialize in women's healthcare for routine and preventive services. Arrangements will be made for specialty care outside of the coverage area when necessary and for emergency and urgent needs, such as dialysis.

Blue Advantage beneficiaries can continue enrollment or disenroll if they no longer reside in the service area and permanently move to a geographic area designated by Blue Cross as a continuation area. Blue Cross continues to provide healthcare benefits to its Blue Advantage beneficiaries until the contract period expires. This continuation of services exists through hospitalizations and insolvency that may occur on the contract expiration date.

For individuals with serious medical conditions, Blue Advantage follows the same procedures that CMS uses and conducts a health assessment on all new enrollees within 80 days. Blue Advantage ensures that enrollees are informed of specific healthcare needs that require follow-up and receive appropriate training in self-care and other measures, such as care management, to promote their health.

Blue Cross provides CMS with all required information necessary to administer and evaluate the program and provide current and potential beneficiaries with information in order to make informed decisions about their available choices for Medicare coverage. Participating Blue Advantage providers agree to cooperate with any quality and improvement initiatives, medical policies and medical management procedures. Blue Cross shares with CMS the quality and performance indicators regarding enrollee satisfaction with the program health outcomes, and disenrollment rates for beneficiaries enrolled in Blue Advantage for the previous two years.

If Blue Cross terminates Blue Advantage or reduces the service area, a written notice will be given to all beneficiaries in the affected area(s) along with a notice of the effective date of termination or area reduction. Included with that notice will be a description of alternatives for obtaining benefits under the Medicare Plus Program.

Anesthesia

Blue Advantage recognizes services billed by anesthesiologists and certified registered nurse anesthetists (CRNAs). These anesthesia providers must use appropriate modifiers and should report the anesthesia time for the correct allowance calculation. All providers should bill for services rendered utilizing their National Provider Identifier (NPI).

Audits/Review

Blue Cross conducts audits in accordance with Medicare laws, rules and regulations. Other audits will be conducted as needed, such as diagnosis-related groups (DRG) validation, site of care, readmission, etc. Blue Cross may contract with a vendor as a business associate that is covered by the Health Insurance Portability and Accountability Act (HIPAA) to conduct specific audits and/or reviews. Examples of possible reviews include:

- Risk adjustment
- Healthcare Effectiveness Data and Information Set (HEDIS)

Medical records may be requested by mail or obtained by on-site imaging at the provider's office and/or facility. The on-site reviewer will have the capability to scan and copy medical records as well as the technology to access Electronic Medical Records (EMR). Providers are required to provide medical records in order for Blue Cross to fulfill state and federal regulatory and accreditation obligations. If a reviewer cannot copy records, Blue Cross will reimburse providers a reasonable cost for the duplication of the medical records.

Note: Providers are required to complete specified courses on an annual basis. Per the Medicare Advantage Provider Agreement, Section 4.16, you should maintain a copy (may be electronic) of your attestation for 10 years for audit purposes.

Claim Denials

Blue Advantage complies with all CMS regulatory requirements for claim denials and the accuracy and timeliness of denial notices. Medicare law regulates claim payment and service authorization processes for Medicare Advantage members, ensures that members receive the benefits they are entitled to, and maintains members' rights to appeal any adverse coverage determination.

Coding

Blue Advantage recognizes all the procedure and diagnosis codes utilized by traditional Medicare. For example, the Healthcare Common Procedure Coding System (HCPCS) administration "G" codes that Medicare uses may be accepted as well as the 90000 series Physicians' Current Procedural Terminology (CPT) codes.

Common Claim Errors

The goal of this section is to reduce common errors that result in claim rejections or claim denials. Most claim denials or rejections are a result of:

- Billing/data entry errors
- Non-compliance with coverage policy
- Billing for services that are not medically necessary

Proper payment of Blue Advantage claims is a result of the joint efforts of providers, clinicians and billing personnel. Meeting this goal also requires complying with national and local medical policies and criteria.

What Constitutes a Billing/Claim Filing Error?

In many cases, Blue Cross cannot pay a claim as it was initially submitted because the claim needs additional documentation or a correction to the claim data. Billing or data entry errors/omissions generally indicate that required fields were left blank [e.g., no International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) admitting diagnosis code entered in Field Locator (FL)/Block 76 of the claim form].

Errors also occur when an improper bill type is used. An example of a bill type error is when a claim is submitted with a discharge bill type, but the status code indicates the patient is still in the facility.

The following are common billing errors that result in claim denials:

- Incorrect member alpha-prefix and ID number
- Invalid/missing diagnosis code or procedure code
- Claim filed after the timely filing limit
- Incorrect provider number
- Missing, incorrect or invalid modifier
- Missing or incorrect quantity billed

Compliance with CMS Regulations

Participating providers with Blue Advantage must adhere to the terms and conditions of the CMS contract. All Blue Advantage participating providers are required to accept the same terms and conditions where appropriate. Compliance with the following CMS regulations is required:

- Healthcare providers are prohibited from holding a member liable for amounts that are the obligation of Blue Advantage.
- Providers must safeguard the privacy of any information that identifies a member and must maintain records in an accurate and timely manner.
- Providers must submit all data necessary to demonstrate the content and purpose of each encounter with the member.
- Providers are prohibited from discriminating against any member based on health status.
- Providers must provide all services in a manner consistent with professionally recognized standards of healthcare.
- Providers are subject to all laws applicable to individuals/entities receiving federal funds and must comply with all other laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.
- Providers must comply with Medicare appeal/expedited appeal procedures for beneficiaries.
- Any payment and incentive arrangements among Blue Advantage and providers, first-tier entities, and downstream entities shall be specified in all contracts.
- Providers must comply with all federal laws and regulations designed to prevent fraud, waste and abuse including, but not limited to, applicable provisions of the federal criminal law, the False Claims Act, the anti-kickback statute, and HIPAA administrative simplifications rules at 45 CFR parts 160, 162 and 164.
- Providers are required to complete the following training annually:
    - Combating Medicare Parts C and D Fraud, Waste and Abuse
    - Medicare Provider Compliance Tips

Providers must comply with the auditing and duplication of billing, payment and medical records requirements that pertain to members.

- Providers must comply with the limitations placed on imposing influenza or pneumococcal vaccine copayments.
- Providers must comply with the provisions regarding member advance directives in a member's medical record.
- Providers must comply with the provisions on risk adjustment data submissions.
- Providers agree to comply with the provisions on maintaining medical policies and procedures.
- Providers must comply with the requirements for billing a member for services not covered by Blue Advantage.
- Providers must comply with the obligation to repay Blue Cross for services paid incorrectly.

Blue Cross must comply with CMS' requirements to provide written notice of suspension or termination to a provider as well as appeal rights. Blue Advantage will adhere to all CMS marketing provisions with regard to marketing and enrolling members into the program.

Electronic Data Interchange (EDI) and eSolutions

EDI is a way for you to send and receive information about your claims as well as eligibility and benefits information about your patients electronically versus by paper or telephone. It is a more efficient way to perform the daily business functions of healthcare.

The submission and retrieval of information electronically can save you time and money by decreasing paper and postage costs and eliminating the need to call Customer Service. When the information you need is available at your fingertips, more flexibility in how and when tasks are performed is possible.

The following information is available for electronic access:

- Care Alerts
- Claims Entry
- Claims Audit Reports
- Claim Status
- Member Eligibility and Benefits
- Remittances
- Payment History
- Referrals
- Precertifications

Getting Started with EDI/eSolutions:

- Options for Accessing Electronic Data with Blue Cross
- Questions for Prospective Vendors
- Vendor Functionality Matrix

Health Management

The Blue Advantage Case Management program is staffed by the Health Management Division of Blue Cross. Led by the Vice President and Medical Director, and staffed by board certified physicians, experienced case managers, physical therapists, and social workers, the Blue Advantage program offers a variety of services promoting efficient delivery of care, improving quality of care, while ensuring medically appropriate services.

Nurses, case managers and others can help the members follow their physicians' treatment plans. We want to help the physicians ensure they have good outcomes with their patients. Blue Cross can receive patient referrals and perform outreach to these members. Provider Customer Service can transfer a provider to Case Management for patient referrals. Additionally, providers can contact the Care Coordinator at 1-888-341-5030 concerning patient referrals.

Identifying a Blue Advantage Member

Blue Advantage members have a Blue Cross and Blue Shield of Alabama identification (ID) card and should provide their ID card when requesting services. The "MA" in the suitcase indicates members who are covered under the Medicare Advantage Preferred Provider Organization network sharing program.

The front of the card includes:

- The member's name, also called the enrollee, subscriber or contract holder
- The member's prefix and ID, also called the contract number, made up of characters either alpha or numeric
- The group number

The back of the card includes important addresses, telephone numbers, and claim filing instructions.

The three-character alpha prefix at the beginning of a member's identification number is the key element Blue Cross uses to identify and correctly route claims. Providers should still verify each member's coverage and plan via Eligibility and Benefits on *ProviderAccess*. To ensure accurate claims processing, it is critical that providers capture all ID card data. If the information is not captured correctly, providers may experience a delay in claims processing. Providers should make a copy of the front and back of the member's ID card, and provide the key information to their billing staff.

Important Telephone Numbers

Please see the "Contact Us" page on *ProviderAccess* for a comprehensive listing of phone numbers.

Mandatory Medicare Outpatient Observation Notice (MOON)

The standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611, is available. All hospitals and critical access hospitals (CAHs) are required to provide the MOON, per CMS guidance, to all Medicare beneficiaries. This notice informs patients that they are being treated as outpatient receiving observation services and not as inpatient of the hospital or critical access hospital (CAH). You should begin providing the form no later than March 8, 2017, to patients receiving observation for more than 24 hours.

The MOON form is mandatory under the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act).

Medical Policies

Blue Advantage medical policies are based on the most current medical research available at the time of the policy development. On this site we offer our final medical policies and draft medical policies. The draft policies are available for physician comment for 45 days from the posting date found on the document.

Go to **AlabamaBlue.com/providers/policies** to view and search for medical and drug policies.

We encourage practicing physicians to provide input.

Policies are written to cover a given condition for the majority of people. Each individual's unique clinical circumstances may be considered in light of current scientific literature. Medical policies are based on constantly changing medical science and Blue Cross reserves the right to review and update our policies as necessary.

Local Coverage Determinations

If the policy you are searching for is not listed in the Blue Advantage medical policies, please refer to the following local coverage determinations sites*:

- Palmetto GBA RHHI Local Coverage Determinations*
- CIGNA Government Services DME MAC Jurisdiction C Local Coverage Determinations*
- Blue Advantage will follow Palmetto GBA MolDX* when there is no Local Coverage Determination or National Coverage Determination related to a Molecular Diagnostic Test.

Effective for dates of service on and after February 26, 2018:

- Palmetto GBA, LLC MAC – **Part A Local Coverage Determinations* / Articles***
- Palmetto GBA, LLC MAC – **Part B Local Coverage Determinations* / Articles***

Effective for dates of service prior to February 26, 2018:

- **Cahaba Government Benefit Administrators, LLC MAC – Part A Local Coverage Determinations**
- **Cahaba Government Benefit Administrators, LLC MAC – Part B Local Coverage Determinations**

National Coverage

If the policy you are searching for is not listed in the Blue Advantage medical policies or the local coverage determinations, please refer to the **CMS National Coverage Database***.

***Note:** These links will take you out of the Blue Cross website. These sites are not the responsibility of, or under the control of, Blue Cross.

Medicare Learning Network

Visit CMS' **Medicare Learning Network** to view MLN Matters articles.

Medication Therapy Management (MTM)

CMS requires that all Medicare Part D plans offer a Medication Therapy Management program (MTM). This program is for members who meet certain CMS criteria around chronic conditions and out-of-pocket prescription drug expense. Members who qualify for this program tend to have the highest number of providers and specialists, and the program aims to promote coordinated care and improve medication adherence.

If you are contacted by MTM pharmacists or nurses to discuss your patient's medications, we encourage you to work with them and consider medication changes as appropriate. The information requested from you is intended to supplement and coordinate your patient's care. It is not intended to substitute your clinical judgement.

The MTM program offers members an opportunity to have a Comprehensive Medication Review (CMR) conducted with the member by clinical staff. We are able to provide the member a comprehensive look at their medication utilization using their prescription drug claim history, and we can alert them to any potential issues. This service is free of charge to the member and serves to reinforce prescriber guidance around their medications in an effort to increase drug efficacy while reducing potential side effects or drug-to-drug interactions.

Should your member qualify for this service, please encourage them to contact us to complete the review at 1-866-686-2223.

Member Appeals and Grievances

Blue Advantage members have the right to file grievances and appeals so they may have timely reconsiderations and resolutions in the event of disputes regarding determinations made by Blue Cross. Members are provided with information describing these rights upon enrollment. In addition, any provider, whether participating or not, may request a determination to verify that a member is entitled to certain benefits under Blue Advantage.

Blue Advantage providers can only appeal post-service determinations on behalf of the member, if the member provides an appointment of representative (AOR) form or equivalent. Be sure to include the member's written authorization with the appeal.

Contact Customer Service to resolve claim issues.

Member Eligibility and Benefits

Visit bcbsalmedicare.com for a brief summary of Blue Advantage member eligibility and benefits. Access to the Summary of Benefits for each plan is available through "Compare & Enroll."

Be sure to always verify each member's eligibility and benefits through *ProviderAccess* or your practice management software.

Potentially Noncovered Services and FAQs

Per CMS, providers may bill a Medicare Advantage patient for a potentially noncovered service after a Pre-Service Organization Determination is submitted and a Standardized Denial Notice has been provided to the patient. A Pre-Service Organization Determination is not required for statutorily-excluded services that have been clearly communicated to the patient. Complete the form, when applicable, for patients who need a Pre-Service Organization Determination.

Refer to the Inpatient Procedures Requiring Precertification for Blue Advantage List in Eligibility & Benefits to verify if a Pre-Service Organization Determination is needed for a specific procedure. The CPT codes listed on this document fall outside of CURP (Concurrent Utilization Review Process). Call Provider Customer Service to initiate the precertification process.

Frequently Asked Questions:

Can I use an Advance Beneficiary Notification (ABN) or a similar form?

No, ABN's and similar forms can't be used with Blue Advantage members.

What does this mean?

Providers who do not obtain a Pre-Service Organization Determination for services that are not covered by Blue Advantage will have their claims processed showing no patient liability. The service will show as a write off and you will not be able to bill the member for the denied portion of the claim.

When do I request a Pre-Service Organization Determination?

Prior to rendering the service, you must determine whether an item or service is covered by your patient's Medicare Advantage plan. You can use *ProviderAccess* or call the number on the back of the patient's card.

- If the service doesn't meet coverage criteria the ordering provider and the member will receive a Notice of Denial from Blue Advantage.
- Upon receiving the denial if the member decides to proceed with the service it is patient liability.

How long does it take to complete a Pre-Service Organization Determination?

Under CMS guidelines, Blue Cross has 14 calendar days from the time the request is received to make a standard decision and notify the member and the provider.

- You may request an expedited Pre-Service Organization Determination if you believe waiting for a standard decision could place your patient's life, health or ability to regain maximum function in jeopardy. Please submit all medical records at the time of the request. An expedited Pre-Service Organization Determination is completed within 72 hours from receipt.

Primary Care Incentive Program

Blue Cross provides the Blue Advantage Primary Care Incentive Program to our physicians who practice in one of the following primary care specialties – internal medicine, family practice, general practice or geriatrics. **Information and materials about this program** are available on *ProviderAccess*.

Proof of Accreditation for Diagnostic Imaging

Providers who offer advanced diagnostic imaging services to Blue Advantage (PPO) members must provide proof of accreditation to Blue Cross and up expiration of their accreditation in order to continue to render these services and bill Blue Advantage (PPO). This is in accordance with the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), Section 135(a), which states:

"Physicians, non-physician practitioners and independent diagnostic testing facilities providing the technical component (TC) of diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine, such as positron emission tomography (PET) services, must be accredited by January 1, 2012."

Our Blue Advantage plan must follow Medicare's advanced diagnostic imaging accreditation and billing guidelines. Providers who currently participate in our Preferred Radiology Program (PRP) will not be required to submit proof of accreditation. However, if you participate in the PRP and have a nuclear medicine accreditation, you must submit proof of that accreditation.

Accreditation does not apply to the professional component (26) of the imaging procedure and hospitals are excluded.

The accreditation organizations approved by the Centers for Medicare & Medicaid Services (CMS) are the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission. For a list of procedures that will require accreditation, refer to CMS' Advanced Diagnostic Imaging Accreditation policy.

You can mail, fax or email the accreditation documentation to:

Blue Cross and Blue Shield of Alabama
Attention: Provider Credentialing
Post Office Box 362142
Birmingham, Alabama 35236-2142

Telephone: 205-220-6765
Fax: 205-220-9545
Email: **credentialing@bcbsal.org**

If you have any questions concerning your participation in the Blue Advantage program, contact your Provider Networks Consultant toll-free at 1-866-904-4130.

Be sure your entire staff knows you are a Blue Advantage participating provider.

Provider Enrollment and Participation

Blue Cross offers eligible providers in Alabama an opportunity to participate with our Medicare Advantage PPO Network program. These network participants provide care to Medicare eligible beneficiaries and Blue Cross reimburses for covered services at the agreed upon payment rate.

What providers are eligible for participation?

- Moderate to high-risk providers as defined by CMS must participate.
- Providers who have opted out of or have been excluded or precluded from the Medicare program are not eligible.
- Providers must participate in Blue Cross' Preferred or Participating networks when applicable. If there is not a Blue Cross network for a provider's specialty, the provider is still eligible for the Blue Advantage network (may require active enrollment in the Medicare program).

If a provider is a Medicare eligible provider and does not currently participate with Medicare, can they become a Blue Advantage provider?

To participate with Blue Advantage, a provider must be a Medicare eligible provider and a participating provider in traditional Medicare.

Can a provider participate with Blue Advantage at one location and not at another?

A provider who chooses to participate will be considered a participating provider at all their locations.

How does a provider apply for participation in Blue Advantage?

If you are an eligible provider and interested in participating in the Blue Advantage network, complete the **Network Interest Application Form** and fax it to 205-220-9545 or mail it to the address below:

Blue Cross and Blue Shield of Alabama
Attention: Credentialing
Post Office Box 362142
Birmingham, Alabama 35236-2142

Be sure to check the Blue Advantage–Medicare Advantage Program box.

Credentialing will review your application and notify you of the next steps. Once you become a Blue Advantage (PPO) provider, be sure your entire staff is aware of your participation.

Provider Referrals

When referring patients to providers outside of your practice, referrals should be made only to other in-network participating providers as required by your Blue Cross and Blue Shield of Alabama participating provider agreement.

In our **Medicare Advantage Participating Provider Agreement**, Section 4.10 states the following: "Participating Provider shall refer Beneficiaries only to Participating Provider, Participating Medicare Advantage Facilities, Participating Ambulatory Surgery Centers, and other Medicare Advantage participating entities or individuals. Participating Provider must coordinate services outside of the provider network with the Corporation's health management/medical director or his/her designee, prior to referring Beneficiaries out-of-network."

If a referral to an out-of-network provider is deemed necessary, a pre-service request should be submitted using the **Pre-Service Organization Determination Form** available on *ProviderAccess*.

Qualified Medicare Beneficiary (QMB) Program Billing Prohibition

CMS states that all Medicare providers and suppliers, including pharmacies, may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services. For more information, visit **www.cms.gov** and use the search term "QMB" or review the following CMS materials:

- **Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program**
- **QMB Program FAQ on Billing Requirements**
- **Qualified Medicare Beneficiary Program Billing Requirements**

SilverSneakers®

Blue Advantage members' benefits include the SilverSneakers® fitness program. Members can enjoy gym memberships at 15,000 participating fitness locations across the nation – at no extra cost. Also included: access to signature classes, health education and social events, certified instructors and fitness equipment.

For more information, view the **informational flier** for providers.

SilverSneakers is provided by Tivity Health, Inc., an independent company. The benefit information provided is a brief summary, not a complete description of benefits. Limitations, copayments and restrictions may apply. Benefits may change on January 1 of each year. Tivity Health and SilverSneakers are registered trademarks or trademarks of Tivity Health, Inc., and/or its subsidiaries and/or affiliates in the USA and/or other countries.

Stars and Risk

Each year CMS assigns Star Ratings to reflect its measurement of each Medicare Advantage plan's overall quality. For Blue Cross, this assessment includes our Blue Advantage plan. This Star Rating directly affects our ability to continue to offer the Blue Advantage plan to Alabamians.We are working to increase our Star rating through a Star Rating Improvement Campaign. **The Stars and Risk section** on *ProviderAccess* provides additional information.

Timely Filing Guidelines

Claims must be filed 15 months from the date of service. There may be penalties for violating these filing guidelines.

Timely Processing of Part B Drugs Appeals and Predeterminations

Effective January 1, 2020, the processing time frame for Blue Advantage predeterminations and appeals for Part B drugs will be shortened.

Predeterminations	
Review Type	**New Processing Time Frame**
Standard	72 hours
Expedited	24 hours

Appeals	
Review Type	**New Processing Time Frame**
Standard	7 days
Expedited	72 hours

Transitional Care Management Services

Blue Cross accepts two transitional care management (TCM) Current Procedural Terminology (CPT) codes for services provided to Blue Advantage members who have transitioned in care from a hospital to home. These codes are only accepted for Blue Advantage members.

TCM should include one face-to-face visit within the specified time frames in combination with non-face-to-face services that may be performed by the provider or other qualified healthcare professional and/or licensed clinical staff underhis/her direction. These requirements are outlined for each CPT code below.

99495 Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within **14 calendar days** of discharge

99496 Transitional Care Management Services with the following required elements:

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within **seven calendar days** of discharge

These codes should be used to report managed care services for a patient following a qualified discharge from a hospital, skilled nursing facility or outpatient observation. The services are for a new or established patient whose medical problems require moderate or high-complexity medical decision-making during transitions in care from a hospital to the patient's home, a rehabilitation facility, nursing home or assisted living.

The purpose of these codes is to help prevent the frequency of reoccurring hospital admissions. Prior to submission of claims with these CPT codes, be sure that each required element is met and documented in the patient's medical record.

TruHearing®

Blue Advantage provides routine hearing exams and two hearing aids per year through TruHearing. TruHearing is a registered trademark of TruHearing, Inc.

Frequently Asked Questions

What is the difference between Blue Advantage and the original Medicare program?

The original Medicare program is operated by the Centers for Medicare & Medicaid Services (CMS). Blue Advantage is a Medicare Advantage Preferred Provider Organization (PPO) Plan, offered and administered by Blue Cross. Blue Advantage is designed to give beneficiaries access to comprehensive, affordable healthcare coverage with a strong emphasis on disease management, prescription drug benefits, preventive health services and coordinated care.

Does this product replace C Plus?

Blue Advantage does not replace our current C Plus product. C Plus is a supplemental policy to traditional Medicare. There will be Medicare beneficiaries who choose to stay with the traditional Medicare program and may select C Plus as their Medicare supplement. Blue Advantage is an alternative to the traditional Medicare program. An individual selecting Blue Advantage would no longer have traditional Medicare as their primary insurance and would not need a supplemental policy.

Is there a Blue Advantage Provider Network?

Yes, providers must participate with Medicare. In addition, providers must be participating providers in any applicable Preferred or Participating Program with Blue Cross. Blue Advantage participating providers must sign a participation agreement.

Will there be a Blue Advantage Provider Directory?

Yes, Blue Advantage members are provided a directory of participating providers. Blue Advantage providers in their area are also posted to the Blue Cross Medicare website, bcbsalmedicare.com.

How will a Blue Advantage participating provider be reimbursed?

Blue Advantage is a Blue Cross product, so providers will be reimbursed based on a contracted fee schedule subject to applicable copayments and deductibles as described in the member's benefits that are available through *ProviderAccess* or your practice management software system.

What if a provider is not a Blue Advantage participating provider?

Providers who are not participating in the Blue Advantage program will be subject to out-of-network benefits. These providers are subject to the Medicare Limiting Charge and all the applicable rules for Medicare non-participating providers.

What kind of benefits will the Blue Advantage member have?

Even though Blue Advantage is a Blue Cross product, we are required to ensure that any member has at least the same benefits that they would have if they were enrolled in traditional Medicare. We may not choose to cover the benefits in the same way that Medicare covers and the benefits may be greater but they cannot be less than traditional Medicare. The benefits are available electronically through ProviderAccess or your practice management software system.

Do I file claims to Medicare?

Claims for Blue Advantage members should be filed to Blue Cross. Do not file claims to Medicare with the exception of the following:

- Services related to hospice care
- Services related to clinical trials

All providers should bill for services rendered using their National Provider Identifier (NPI).

What number do I call for Customer Service?

Inquiries for Blue Advantage members should be made by using the phone numbers listed on the **Contact Us** page on *ProviderAccess*.

Acronyms Used in this Manual

ABN: Advance Beneficiary Notification

CAH: Critical access hospital

CFR: Code of Federal Regulations

CMR: Comprehensive Medication Review

CMS: Centers for Medicare & Medicaid Services

CPT: Current Procedural Terminology

DME: Durable medical equipment

DRG: Diagnosis-related groups

EDI: Electronic Data Interchange

EMR: Electronic Medical Records

FAQ: Frequently Asked Questions

FEP: Federal Employee Program

FL: Field Locator

HCPCS: Healthcare Common Procedure Coding System

HEDIS: Healthcare Effectiveness and Information Set

HIPAA: Health Insurance Portability and Accountability Act

ICD-10-CM: International Classification of Diseases, 10th Revision, Clinical Modification

ITS: Inter-Plan Teleprocessing System

M+C: Medicare+Choice

MOON: Mandatory Medicare Outpatient Observation Notice

MTM: Medication Therapy Management

NPI: National Provider Identifier

PAC: Pre-admission certification

PPO: Preferred Provider Organization

PRP: Preferred Radiology Program

TCM: Transitional Care Management

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