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Introduction

Blue Cross and Blue Shield of Alabama’s Personal Choice Network (PCN) is a managed care network committed to total quality care for our customers. First introduced in 1995, the Personal Choice Network is a point-of-service benefit plan. The cornerstone of this plan is the relationship developed between the patient and the Primary Care Physician (PCP). The PCP Network is carefully selected from board certified family practice, internal medicine, pediatric, and geriatric medicine physicians.

The patient determines the levels of benefits that are received. By coordinating care through his/her PCP, the highest level of benefits are received. If the patient chooses not to coordinate care with his/her PCP, benefits are reduced which result in an increase in out-of-pocket expense for the patient.

This manual is intended to be an overview of the Personal Choice Network including the referral process, benefit structure, selection and participation of the PCP.

Important Information

The following disclaimer is applicable to all telephone inquiries and automated communications systems (i.e., telephone and fax) to Blue Cross and Blue Shield of Alabama:

The information provided is only general benefit information and is not a guarantee of payment. Benefits are always subject to the terms and limitations of the plan and no employee of Blue Cross and Blue Shield of Alabama has authority to enlarge or expand the terms of the plan. The availability of benefits is always conditioned upon the patient’s coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur under certain circumstances. There will be no benefits available if such circumstances occur.

Note: Please refer to our website, AlabamaBlue.com/providers, for the most current benefit and policy information.

CPT codes, descriptions, and other data only are copyrighted © 2015 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
PCN Benefit Structure

Alabama Personal Choice offers excellent comprehensive coverage for inpatient and outpatient hospitalization, physician services, prescription drugs, and preventative services. The specific benefits and coverage are outlined below:

- **In-Network Benefits** – Benefits are maximized when services are provided by or coordinated through the member’s PCP. These benefits are referred to as “in-network.” If specialist care is needed, the member’s PCP will refer him or her to an appropriate Preferred Medical Doctor/participating provider. In-network specialist referrals are approved when those services cannot otherwise be provided by the PCP.

- **Out-of-Network Benefits** – Benefits are reduced to the “out-of-network” level when services are not performed or managed by the Primary Care Physician. The term “out-of-network” refers to all services provided without a referral. It also refers to all services performed outside the Blue Cross and Blue Shield of Alabama participating provider service area, which includes the state of Alabama and its contiguous counties. Claims processing under the out-of-network benefit level generally apply to the Major Medical deductible and process thereafter with applicable coinsurance. In some instances, the member may be responsible for the entire amount charged by the physician for the service.

- **Out-of-Area Benefits** – Members who reside outside the network service area (e.g., a college student or other dependents who do not live in the network service area) may request “out-of-area” benefits when enrolling in Personal Choice. The member should call the Customer Service telephone number on the back of the member’s ID card to declare they are an out-of-area resident. When these members receive services outside the network area, out-of-area benefits will apply. These Major Medical benefits do not require a referral. However, when these members receive care from their PCP while in the service area, in-network benefits are applied.

Network Names

Blue Cross has only one Personal Choice Network, but some employer groups have elected to refer to the network by different names. Members with PCN benefits can be identified by their Blue Cross card. The name is located in the upper right corner of the identification card. Network names include:

- Personal Choice
- Alabama Personal Choice

The following are examples of identification cards:
Personal Choice Network Benefit Matrix

In compliance with the Health Care Reform Personal Choice guidelines and effective October 1, 2010, PCN referrals for OB/GYN services will no longer be required. In the past, members were provided the opportunity for only two OB/GYN visits without the need of a referral and those visits were based on specific member benefits on line. As of October 1, 2010, members will have unlimited access to OB/GYN providers and will no longer require referrals.

OB/GYN providers are not among the list of physicians from which patients may choose their primary care physician. Blue Cross continues to identify only pediatricians, family medicine, internal medicine and geriatric providers as eligible primary care physicians for the Personal Choice Network. Please refer to AlabamaBlue.com for more information about Health Care Reform.

Enrollment in the Alabama Personal Choice Plan

Selection of a Primary Care Physician

The selection of a Primary Care Physician (PCP) is the key to this plan. For those groups that choose the Personal Choice Network as their healthcare plan, the subscriber must complete the appropriate enrollment application. The subscriber must choose a PCP for each family member. If a PCP is not selected, one will not be selected for the member and all claims will process at the out-of-network benefit level until such time as the member selects a PCP. Each family member can choose a different physician or they can select the same physician for all family members. Blue Cross has contracted with a select network of physicians to participate in the Personal Choice Program. Our PCP Network consists of a complete range of physician specialties. Following are the specialties included:

- Family Practice
- Geriatrics
- Internal Medicine
- Pediatrics

Current Personal Choice Physicians can be identified online under “Find A Doctor” on the Blue Cross website at AlabamaBlue.com. This will provide assistance to the subscriber in making a primary care physician selection. A paper directory may be requested from Customer Service.

The selected PCP’s National Provider Identifier (NPI) number should be included on the application. If the subscriber or family member is not a current patient of the physician they wish to select as their PCP, it is important to check with the physician’s office to verify that he/she is accepting new patients. Subscribers or any dependents that live outside the network area need to provide that information on the enrollment application. In such a situation, the member does not need to choose a PCP. A PCP should be selected if the subscriber or dependent will be residing in the network area for any extended period (e.g., a student home for the summer). The network area includes the state of Alabama and some physicians in bordering states (contiguous counties).

On the following pages are examples of a PCP selection letter and a no PCP selected letter.
July 15, 2016

John Q. Blue
1st Street
Birmingham, Alabama 35244

Group Number: 12345
Contract Number: XAA123456789

Dear Mr. Blue:

Blue Cross and Blue Shield of Alabama is pleased to administer your benefits plan. You are a valued customer and it is important to us that you maximize your benefits.

Below is a list of the members on your contract who have recently selected or changed their Primary Care Physician (PCP) selection:

<table>
<thead>
<tr>
<th>Member</th>
<th>Primary Care Physician</th>
<th>Selection Effective Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sue</td>
<td>John Jones, M.D.</td>
<td>07/01/2016</td>
</tr>
</tbody>
</table>

Remember, your PCP is responsible for providing or arranging all of your medical care. If you are changing your PCP, any active referrals initiated by your former PCP are no longer valid and will need to be reissued by your new PCP. To maximize your benefits, always consult your PCP first when medical care is needed.

If the information above is inaccurate or if you have any questions, please call the telephone number on the back of your identification card.

Sincerely,

Blue Cross and Blue Shield of Alabama
July 25, 2016

John Q. Blue
1st Street
Birmingham, Alabama 35244

Group Number: 12345
Contract Number: XAA123456789

Dear Mr. Blue:

Blue Cross and Blue Shield of Alabama is pleased to administer your benefits plan. You are a valued customer and it is important to us that you maximize your benefits.

The selection of the Primary Care Physician (PCP) for you and any eligible dependents is the most important part of your participation in this plan because this physician will provide or arrange all of your medical care.

Our records indicate that, as of the date of this letter, a PCP is not currently selected for the member(s) listed below:

Sue

To receive the highest level of benefits, you must select a PCP. Always consult with your PCP first for your healthcare needs. If he or she cannot provide the care you need, you will be referred to a specialist.

It is critical to call the number on the back of your identification card to choose and/or verify your selection of a Primary Care Physician. If you have questions concerning this letter, please call and we will be glad to help you.

Sincerely,

Blue Cross and Blue Shield of Alabama
Monthly Physician Reports

A monthly report with patient names and correct contract numbers is available via ProviderAccess. The report includes new, existing and canceled primary care patients. The report also includes the PCP’s most current covering physicians and referral activity for the month including retroactive referrals. It is important to review the covering physician information and notify Blue Cross Blue Shield of Alabama of any additions or deletions.

Changing Primary Care Physicians

The member’s Primary Care Physician (PCP) can be changed up to twice a year (refer to eligibility and benefits for exceptions). If a PCP withdraws from the Network or ceases to practice medicine, there is usually a 60-day grace period to select a new PCP. Letters are mailed to all subscribers notifying them of the need to select a new PCP. Members are encouraged to confirm that a PCP is accepting new patients before changing PCPs. Once the member has made this confirmation, he/she may contact Customer Service to make the change. It is important to inform members changing PCPs that all existing referrals are null and void. New referrals must be obtained from the new PCP. This policy applies to new PCPs within the same practice or covering for the current PCP. Members should routinely see the PCP they have selected and only see his covering partners in the absence of the PCP.

If a PCP is not selected, a reminder letter will be mailed to the subscriber the second Monday of every month until a selection is made. On the following page is an example of this letter.
July 15, 2016

John Q. Blue
1st Street
Birmingham, Alabama 35244

Group Number: 12345
Contract Number: XAA123456789

Dear Mr. Blue:

Your relationship with your Primary Care Physician (PCP) is an important part of your benefits plan and critical for you to maximize the benefits the Personal Choice Network offers you.

Please note that as of July 1, 2016, Joe Smith, M.D. is no longer participating in our network. According to our records, the following individual on your contract needs to select another PCP:

Jane

Please select another PCP immediately so that everything will be in place when you need medical care. To do this, you need to choose a new PCP from the PCP directory. After choosing a new physician, you should contact his/her office to verify that new patients are being accepted. If the physician you choose will accept you as a new patient, please call Blue Cross and Blue Shield of Alabama and we will update our records to reflect your new PCP selection. After we are notified of your new selection, we will send you a confirmation letter. Note that any active referrals initiated by your former PCP are no longer valid and will need to be reissued by your new PCP.

Be sure to call the Customer Service number on the back of your identification card if you have any questions about selecting a physician, to request a PCP directory or to make your selection by telephone.

Sincerely,

Blue Cross and Blue Shield of Alabama
Personal Choice Selection Process and Credentialing

Physician Qualifications

If a physician indicates that he or she would like to be considered a Personal Choice, the following qualifications must be met:

- Provider must be a Preferred Medical Doctor (PMD) for one year or more
- Provider must be board certified in family practice, geriatrics, internal medicine or pediatric medicine
- Provider must have 24-hour on-call coverage, which cannot be an answering machine directing patients to the emergency room
- Provider must be practicing full time (minimum three days per week)
- Provider cannot work in an urgent care setting
- Provider cannot work in a rural health clinic setting
- Provider must score 80 percent or higher in the scoring process

The provider should contact his or her Provider Networks Consultant to indicate that he or she would like to be considered a Personal Choice Physician.

Primary Care Physician Responsibilities and Expectations

PCPs are selected based on their past relationship with Blue Cross. Applicants are extensively screened once the PMD provider applies to become a PCP physician. The following are responsibilities and expectations of the PCP in addition to providing safe, high-quality care:

- Provide accessibility, availability and accountability in initiating the evaluation management process.
- Be the point of entry for the patient into the healthcare delivery system, providing the initial patient assessment and managing all aspects of patient care within the PCP scope of practice.
- Have appropriate communication and follow-up with any specialist to whom the patient is referred.
- Act as a healthcare resource manager to ensure cost-effective, medically necessary, quality healthcare including:
  - Preventive benefits
  - Special PMD review
  - Appropriate emergency room referrals
- Provide patient access and triage coverage for 24 hours a day, 7 days a week. Answering machines or answering services that direct the patient to the emergency room after hours or allow the patient to make the decision as to whether it is a medical emergency are unacceptable.
- Provide physician triage for acute/urgent conditions to prevent inappropriate emergency room utilization.
- Refer members to PMD providers and participating networks only. Requests for exceptions should be directed to your Provider Networks Consultant.
- Referrals must be entered electronically online into the Blue Cross system in a timely manner. Retroactive referrals will only be allowed for PCP or office error. Referrals will not be entered by faxing a PCN retroactive referral form.

Referral Process for the Primary Care Physician Office

All specialist care must be coordinated through the PCP’s office. Referrals may be entered into the Blue Cross system through:

- E-practice management vendor connection
- Our website, AlabamaBlue.com/providers
**When Referrals are Required**

All specialists require a referral in advance of a patient’s visit. The PCP is required to make a referral in the following instances:

- Sending a primary care patient to another physician for treatment including diagnostic testing by a cardiologist.
- If the “referred to” specialist recommends the patient see another specialist.
- Emergency treatment - The patient must notify the PCP within 48 hours of emergency room care even if admitted to the hospital. A referral is required to the hospital for emergency room visits or emergency room admissions.
- Visits to Participating Chiropractors, Podiatrists and Oral Surgeons.
- Visits to dentists for medical (non-dental) services, such as accidental trauma to natural, sound, existing teeth or temporomandibular joint (TMJ).
- Follow-up visits to a specialist following hospitalization.
- Care by a neonatologist.
- When the Personal Choice Network contract is a secondary insurance policy.

**When a Referral is Not Required**

Referral notification is not required in the situations below:

- Treatment rendered by the PCP.
- Services by laboratories, pathologists, radiologists and anesthesiologists.
- Additional physicians treating or consulting during an in-network hospital admission.
- Ambulance services.
- Physical therapy, occupational therapy, speech therapy, durable medical equipment (DME), or home health when ordered by the PCP or specialist with an effective referral. (Must refer to participating agencies).
- Dentist, unless the services are TMJ related or a result of an accident.
- Veteran’s Administrations and military providers - The system will assign an appropriate level of benefit to indicate in-network.
- Vision care per specific group benefits. **Note: Referrals are not required for optometrists and ophthalmologists.**

**Newborns**

- A PCP should be added for newborns within 30 days of the date of birth. The effective date of the PCP is retroactive to the date of birth if Blue Cross is contacted within 30 days.
- If a PCP is added after the 30-day time limit, the effective date is the date of notification.
- Referrals are required for services performed by a neonatologist.
- If the baby’s hospital charges are included with the mother’s, no referral is needed for the baby. Should the baby’s stay go beyond the span of the mother’s, a referral is required for the baby.
“Other” Referral Policies

- Referrals do not override contract benefits.
- Referrals and precertifications are mutually exclusive of each other. It is possible that a patient not need a referral and need precertification. A predetermination may be obtained from Medical Review for certain proposed treatment plans. Following are definitions of these terms:
  - Referrals - Approval from PCP to see a specialist or be admitted to a facility
  - Precertification - Process by which the determination of the appropriateness of the location of treatment is made
  - Predetermination - A courtesy medical review service designed to provide coverage determination for proposed elective services

Referrals for Emergency Treatment

All emergency room visits require a referral to the facility even if that emergency room visit results in an inpatient admission in order for a claim to pay in-network and at the highest benefit level. It is the responsibility of the member to contact his or her PCP within 48 hours after an emergency room visit. This requirement is the subscriber’s responsibility as set forth in the contract guidelines for this program. It is the PCP’s responsibility to determine the medical necessity for the emergency room visit. If both contract PCN notification guidelines plus medical necessity criteria are met, the PCP’s office should issue a referral. If the patient notifies his or her PCP in advance of emergency treatment, the referral must be made to the hospital and not the emergency room physician. This is true regardless of:
  - The time of that notification (including after-hours)
  - Whether the PCP has ever seen the patient in the office or has a chart on the patient, or
  - Whether the PCP or covering partner directed the patient to the emergency room

Retroactive Referrals

Except in the case of PCP/office error, retroactive (backdated) referrals are not accepted. Effective September 1, 1998, retroactive referrals due to PCP error will be accepted only when submitted with a written request for consideration on the Retro Referral Form. The PCP office has 72 business hours to enter an appropriate medically necessary PCP referral into the system. After 72 hours, a denial will be received for late referrals. All retro referrals (PCP error) must be entered into the Blue Cross System prior to faxing the Retro Referral Form to 205-220-5763 or 1-800-303-8930. The referral form will be reviewed by the Blue Cross PCN area for appropriateness before approval is given. If the referral is approved, claims will automatically reprocess if the claim’s processed date (adjudication or transaction date) is less than six months. All claims greater than six months old will require special consideration for the claims to reprocess.

Members contacting Customer Service regarding a referral are advised that the PCP can only issue a late referral when the patient has complied with the program guidelines. If the subscriber chooses to seek specialist care without a referral, benefits will be at a reduced level per their benefits plan. The retro referral rate is documented on the PCP’s monthly report and is monitored by Blue Cross. Blue Cross requires a 10 percent or less retro referral rate be maintained. Those offices with a higher retro referral percentage are subject to further review, analysis, discussion and educational intervention. Patients should only see the covering physician during the absence of the PCP.

On the following page is a sample Personal Choice Network Retro-Referral Form.
If a referral was not completed due to PCP error, please enter the referral in your usual method and then fax this completed form explaining the circumstances to 1-800-303-8930 or 205-220-5763.

For assistance in entering the referral, call Customer Service at 1-877-231-7239.

**This form cannot be used for Select referrals.**

**Primary Care Physician Information**

<table>
<thead>
<tr>
<th>Physician Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Provider Identification Number (UPIN)</td>
<td>Individual NPI (National Provider Identifier)</td>
<td></td>
</tr>
<tr>
<td>Office Contact</td>
<td>Hospital/Clinic</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip</td>
</tr>
<tr>
<td>Office Telephone</td>
<td>Fax Number</td>
<td>E-mail</td>
</tr>
</tbody>
</table>

**Patient Information**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Contract Number (include prefix)</td>
<td>Group Number</td>
</tr>
<tr>
<td>Contract Holder’s name (if different than patient)</td>
<td>Relationship to Patient</td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis Information**

**Referral Information**

<table>
<thead>
<tr>
<th>Referred to Specialist or Hospital name</th>
<th>Unique Provider Identification Number (UPIN)</th>
<th>Individual NPI (National Provider Identifier)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Dates: From</td>
<td>To</td>
<td># of Visits (Optional)</td>
</tr>
</tbody>
</table>

Please state briefly why the referral was not completed within 72 hours of the appointment or any additional comments.

**NOTE:** Open-ended referrals (no through dates) to specialist will cancel after two months. Referrals should not exceed 12 months. Referrals to facilities for ER visits or ER admissions are per episode and should not be created for one month at one time.

Form not complete and information provided cannot be used until signed.

Signature of Referring Physician

Date

Status

Number

(Rev. 2/2016)
Specialist Seeing Personal Choice Network Patients

When treating a patient who has a benefit plan that requires a referral from the PCP, it is the patient’s responsibility to make sure the proper steps have been taken to ensure a referral has been obtained. The specialist may view the referral online at AlabamaBlue.com/providers. To view the referral, the specialist office must have a password to access the secured site. The specialist may not refuse care to a Blue Cross patient because the referral has not been obtained. Many contracts offer an out-of-network benefit allowing the member to obtain physician care without a referral. Effective April 1, 2001, if a PCN patient sees a PMD physician and the claim processes out-of-network, the PMD physician cannot bill any charges over the PMD allowance (any out-of-network deductibles and coinsurance will still apply).

Out-of-Network Referrals

Referrals by the PCP should be made only to PMDs and participating hospitals. The referral system will automatically deny any attempt to enter referrals to non-PMD physicians. Referrals to non-PMD physicians except in an emergency situation (i.e., accident or illness while on vacation) are subject to review by Blue Cross’ Medical Director. These referrals are only approved in the event the service is not available within the PMD network and is a recognized standard of care (excluding experimental treatment).

Requests for review of out-of-network referrals should be made prior to the patient seeking out-of-network treatment. To expedite this medical review process, please fax the following information to 205-220-5763 or 1-800-303-8930:

- Pertinent medical records from the PCP and all specialists treating the patient for this disorder
- Information regarding prior treatments and proposed/requested out-of-network treatment modalities
- Medical necessity request letter from the PCP and PMD specialists who have treated the patient for this disorder, citing the reason for the out-of-network referral request
- Diagnosis code
- Name, address, telephone number, NPI or tax ID number for the referred to non-PMD specialists
- Patient’s contract number, name, and date of birth
- Any information from the PCP and/or PMD specialist regarding availability of services in Alabama

Be sure to let Blue Cross know if the PCP is sending the patient to a non-PMD for a consultation/second opinion only or for a consultation plus treatment.

Blue Cross reviews all requests prior to a decision being made. The PCP’s office is notified by telephone of the outcome of the review. If the request is denied, the PCP office is advised to notify the member of the decision and encourage them to contact Customer Service to verify out-of-network benefits. If the subscriber chooses to seek specialist care without prior approval, benefits will be at a reduced level per their benefit plan and may, on occasion, result in total denial of payment.

Requests for referrals while the patient is traveling in another state, such as on vacation, will be handled as other in-network referrals. The patient has 48 hours to notify the PCP of the illness or accident. The event will be reviewed by the PCP to determine the medical necessity of the visit. The referral should be entered in the usual fashion. A provider number, NPI or UPIN should be acquired for the referral. If none are available, a tax identification number should be requested. The Blue Cross PCN staff or Customer Service will assist with entering these referrals. If a provider number, NPI or UPIN is not identified for the treating provider, the referral will be entered with the PCP’s NPI/UPIN as the “referred to” physician until the claim has been submitted and numbers are identified. In-network benefits will apply.
Out-of-Country Referrals

Emergency services performed out of the United States may receive in-network benefits if coordinated through the PCP. Services that are deemed medically necessary but not coordinated with the PCP will be considered at the out-of-network level. Routine services can never be considered at the in-network benefit level.

Any out-of-country claim submitted must include the following:

- Charges must be completely itemized with a description of each service and a charge for each service
- Charges must be converted to American dollars using the foreign exchange rate at the date of service
- All charges must be translated into English
- Hospital code 010-196 or provider number 510-55118 must be used

Covering Physicians

To ensure Personal Choice Network members have the best possible coverage, all PCPs are required to have covering physicians. PCPs should designate a PMD physician. As stated in Section III (1) of the PCN Physician Agreement, “covering physician must hold current status as a Preferred Medical Doctor (PMD).” Non-PMD physicians will not be accepted as covering physicians.

The PCP should send a letter to the Blue Cross PCN area indicating which physicians will cover for them in their absence. The letter should include the provider numbers and/or NPIs of the covering physicians and the effective date. A covering physician can act as the PCP. Patients should only see the covering physician during the absence of the PCP. This information may also be added in ProviderAccess.

A covering physician must be on call 24 hours a day. An answering machine referring the patient to the emergency room will not be sufficient.
Personal Choice Network Referrals Online

Network referrals can be completed online as follows:

- Go to our provider website, AlabamaBlue.com/providers.
- Log into ProviderAccess (located on the left side of the screen).
- Be sure to use the Personal Choice Network option for managing referrals.
- You will see the following screen:
Example – PCN Referral Letter

July 15, 2016

John Q. Blue
1st Street
Birmingham, Alabama 35244

Contract Number: XAA123456789

Dear Mr. Blue:

The following referrals for your contract number have been accepted. You do not need to take any further action on these referrals, however, please pay particular attention to the covered dates and number of visits. It is your responsibility to notify your Primary Care Physician when the referral expires if additional time is needed or additional visits are needed.

Remember, your Primary Care Physician must initiate referrals when care by a specialist is needed. If any family member selects a new Primary Care Physician, referrals by the former Primary Care Physician are no longer valid. Benefits are subject to medical necessity criteria as well as the terms, limitations, and conditions of your specific contract.

We appreciate the opportunity to administer your benefit plan and hope the above information is helpful. If you have questions regarding your referrals, please contact our Customer Service Department at the number on the back of your identification card.

Sincerely,

Blue Cross and Blue Shield of Alabama
Example – Point of Service Referral Report

May 16, 2016

Dr. John Blue
2nd Street
Birmingham, Alabama 35244

POINT OF SERVICE REFERRAL REPORT
FOR: Dr. Timothy Jones

PATIENT NAME  BIRTH  FROM–THROUGH VISITS  CONTRACT  REF NO  REFERRED TO
PUBLIC    J Q 01011960 04032016–04032016   24   XAA123456789 A1234568  Smith Jane

TOTAL PATIENTS FOR DR. John Blue            1
ALL BENEFITS CONTINGENT UPON TIMELY PREMIUM PAYMENTS
AND ELIGIBILITY AT TIME OF ADMISSION.

Example – Monthly Point of Service Referral Report

April 4, 2016

COMMUNITY HOSPITAL
PO BOX 1234
BIRMINGHAM, AL 35202

POINT OF SERVICE REFERRAL REPORT

ACCEPTED REFERRALS

PATIENT NAME BIRTH DATE  FROM  THROUGH VISITS  CONTRACT  REF NO  REFERRED BY
JONES   V L 06/01/1973 04/01/2016 04/01/2017   XAA111222333  A1111111  Jane Smith
SMITH   WC 09/01/2004 03/02/2016 03/02/2017   XAA123456789  A2323232  Joe Jones

DENIED REFERRALS

PATIENT NAME BIRTH DATE  FROM  THROUGH VISITS  CONTRACT  REF NO  REFERRED BY
SIMS   B S 03/03/1971 04/01/2016 04/01/2017   XAA444555666  D1111113  Jane Smith
SIMS   B S 03/03/1971 04/01/2016 04/01/2017   XAA444555666  D2222221  Jane Smith
SIMS   B S 03/03/1971 04/01/2016 04/01/2017   XAA444555666  D3333333  Jane Smith

Please note that if you need to refer this patient to another specialist or hospital Emergency Department, a SEPARATE referral is required from the Primary Care Physician.

The referral should be received within 72 hours of a specialist visit or visit to the hospital Emergency Department.

THE AVAILABILITY OF BENEFITS IS ALWAYS CONDITIONED UPON THE PATIENT’S ELIGIBILITY AND THE EXISTENCE OF A CONTRACT FOR BENEFITS AS OF THE DATE OF SERVICE.
Example – Personal Choice Physician Report – Inactive

R123456M78

RUN DATE 5/16/2016    DATA AS OF 4/01/2016

PROVIDER NAME: Jack Smith    SORTED BY CONTRACT#
PROVIDER UPIN: H12345
PROVIDER ADDRESS: 1st Avenue, TUSCALOOSA, AL 35406-2804
TOTAL PERSONAL CHOICE PATIENTS: 2

Jack Smith
1st Avenue
TUSCALOOSA AL 35406-2804

CURRENT PERSONAL CHOICE PATIENTS

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<tr>
<th>PATIENT NAME / SSN</th>
<th>CONTRACT#</th>
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NEW PERSONAL CHOICE PATIENTS

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<td>4TH AVE E EUTAW, AL 35462-9701</td>
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CANCELLED PERSONAL CHOICE PATIENTS

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CURRENT LIST OF COVERING PHYSICIANS

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<th>PROVIDER NAME</th>
<th>UPIN</th>
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<td>NO COVERING PHYSICIANS ON FILE FOR UPIN#H12345</td>
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REFERRAL ACTIVITY FOR 04/01/2015–04/01/2016

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<th>CONTRACT#</th>
<th>CONFIRMED#</th>
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<th># STATUS</th>
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Provider Appeals

As of April 21, 2009, Blue Cross established an appeals process for providers and physicians. The following documentation provides guidance regarding the process for appeals.

An online form is also available to aid providers in preparing an appeal request. Adobe version 7.0 or greater is required for using the appeal form. To access the online form, go to AlabamaBlue.com/providers. Within “Policies & Guidelines,” click on “Provider Appeals” to download the latest version. The form can be completed online and printed or printed as a blank document to complete by hand. When the form is completed online, the form will automatically receive a barcode that expedites the handling of your request.

Provider Post-Service Claim Appeal Process Questions and Answers*

*Not applicable to predeterminations, provider audits or appeals regarding termination from network. Does not apply to Blue Advantage®.

What is an appeal?

An appeal is when a provider formally requests (via appeal form or letter) a reconsideration of a previously adjudicated claim that may or may not include additional information.

Examples of appeals include, but are not limited to the following:

- Payer allowance
- Medical necessity (including cosmetic and investigational)
- Incorrect payment/coding rules applied
- Errors in administration of coordination of benefits (COB), coinsurance/deductibles, coverage/benefits, eligibility, timely filing

Following are examples of what is not considered a provider appeal:

- Corrected claim
- Provider complaints regarding medical policy
- Contracting issues
- General inquiries/questions
  - Provider request to “review” a claim
  - Pricing issue not associated with a post-service claim
  - Scope of practice
  - Any claim denied needing additional information
  - Unsolicited medical records
  - Provider appeal on behalf of member (see member appeal process)
  - Notes written on copies of claim forms or provider remittances without supporting documentation
When can I request an appeal?

Blue Cross will perform a single internal appeal as a courtesy to the provider when there is an adverse benefit determination as described above. Providers should also refer to their Participating or Preferred agreement for dispute resolution options.

**Note:** The provider may not initiate an internal post-service appeal or external review of any denied service if the member filed a pre-service appeal pertaining to the same denied service the member (or his/her representative) is currently seeking or has sought review related to the same denied service. In the event the member (or his/her representative) and the provider seek review of the same denied service, the member’s review shall go forward and the provider’s request for review will be dismissed.

What is the timeline for conducting an appeal?

In most cases, the provider has 180 days following an adverse determination within which to submit an appeal. Post-service claim appeal reviews will generally be completed within 30 days of receipt of all documentation reasonably needed to decide the internal appeal. When the provider is the member’s authorized representative, the timeline for appeal submission and completion is defined in the member’s Summary Plan Description (SPD).

How do I request an appeal?

Providers should submit a formal request via the appeal form that has been developed for use by providers. The form can be found at [AlabamaBlue.com/providers](http://AlabamaBlue.com/providers). A letter may also be submitted that contains the following information:

- The reason for the appeal;
- The patient’s name;
- The patient’s contract number;
- Sufficient information to reasonably identify the claim or claims being appealed, such as date of service, provider name, procedure, and claim number; and
- A statement that the request is for an appeal

Please be sure to include any supporting information or explanation, including any relevant procedural notes, chart notes and/or medical records as appropriate to the review.

Where do I send my appeal request?

All appeal correspondence should be submitted to the following address or fax number:

Blue Cross and Blue Shield of Alabama Appeals
Post Office Box 10408
Birmingham, AL 35202-0408
Fax: 205-220-9562

What if I disagree with an initial appeal determination?

If the provider has completed the initial internal appeal, any subsequent appeal rights will be defined by their Participating or Preferred provider agreement or legal settlement then in effect with the provider.

Physicians participating in the Love Settlement agreement may qualify for an external review process after exhaustion of the Blue Cross initial internal appeal process.

**Note:** Love Settlement guidelines do not apply to Blue Advantage patients.
Physician External Review Process
IMEDECS has been selected as the Billing Dispute Resolution Reviewer and Independent Review Organization for Medical Necessity Disputes under the terms of the Love Settlement agreement.

Physician Billing Disputes
This review process seeks to resolve disputes concerning application of coding and payment rules and methodologies for fee-for-service claims to patient specific factual situations. Included is bundling, downcoding, application of a Physicians’ Current Procedural Terminology (CPT) modifier, and/or other reassignment of a code. An individual medical doctor or medical doctor group must exhaust the initial internal appeal process described above and the dispute must exceed $500 to qualify for the external billing dispute process. The physician or physician group may submit a billing dispute for less than $500 if IMEDECS is notified that additional billing disputes with similar issues during the one year period following the submission of the original billing dispute are forthcoming. IMEDECS will defer consideration of the dispute while the physician accumulates additional similar disputes. A filing fee, dependent on the amount in dispute, must also be submitted with the request.

Physician Medical Necessity Disputes
This review process seeks to resolve disputes concerning services that are determined to be non-covered due to not being medically necessary or are experimental or investigational in nature. The physician must exhaust the post service internal appeal process to qualify for the external review process. The physician may submit a written request to IMEDECS within 60 days from the date of the internal post service appeal non-coverage decision or may submit an online request. Visit AlabamaBlue.com/providers and select Provider Disputes within Policies & Guidelines, located under Resources. Physicis seeking external review shall pay a filing fee of $50 if the amount in dispute is $1,000 or less or $250 if the amount in dispute exceeds $1,000. Payment must be submitted with the review request. Note: If using a written IMEDECS Solutions’ request form, submit it to the address below:

IMEDECS Attention:
Jimilou Budusky
100 West Main Street, Suite 310
Lansdale, PA 19446
Telephone: 215-855-4633, ext. 324
Fax: 215-855-5318

Pre-Service Appeals and Concurrent Appeal Process

What is a pre-service or concurrent appeal?
Providers may file an appeal of an adverse determination prior to rendering the service (pre-service) or during an ongoing course of treatment (concurrent) if they are appealing on behalf of the member. For urgent pre-service appeals, the provider is automatically deemed the authorized representative of the member. For all other appeals, authorization must be obtained from the member in writing.

Examples of Pre-Service Appeals include, but are not limited to the following:
• Preadmission Certifications
• Precertification of Therapy Services for Preferred Care Contracts
• Precertification of Radiology Services
• Pre-Procedure Review
The following are examples of what is not considered a pre-service appeal:

- Predeterminations are a courtesy pre-review of physician services not requiring precertification under the member’s contract, but that are possibly non-covered because they are considered investigational or cosmetic and for durable medical equipment (DME) over $3,000
- Referrals by a PCP for a recommended specialist or treatment

What is the timeline for conducting an appeal?

The below timelines generally apply for most members:

- Urgent pre-service or concurrent appeals will be completed within 72 hours
- Standard pre-service or concurrent appeals will be completed within 30 days (some groups may have other specific requirements)

How do I request a pre-service or concurrent appeal?

To request a pre-service appeal or extension of care, call the telephone numbers below:

- For inpatient hospital care, call 205-988-2245 (in Birmingham) or 1-800-248-2342 (toll free)
- For Preferred Physical Therapy, Occupational Therapy or care from a Participating Chiropractor, call 205-220-7202
- For Preferred Radiology Services, call 1-866-803-8002

To request an appeal for Preferred Radiology Services, submit your request to the address or fax number below:

eviCore healthcare - Attention: Clinical Appeals
400 Buckwalter Place Blvd.
Bluffton, SC 29910
Fax: 1-866-699-8128

What if I disagree with an initial appeal determination?

If the appeal continues to uphold the original adverse determination, the member’s appeal rights will be defined in their SPD.

Can I appeal a courtesy predetermination?

Predeterminations are provided by Blue Cross as a courtesy to our physicians and members for certain physician services that may or may not meet our medical policy criteria. These predeterminations are not a requirement of the member’s or physician’s contract, so they do not carry any formal pre-service appeal rights. In those instances where a predetermination decision has been provided, the provider or member may submit additional documentation for reconsideration. This additional information should include a letter asking for reconsideration that includes any and all information needed to make a decision. Only one reconsideration will be allowed per case. The contacts for predeterminations are as follows:

Courtesy Predetermination Reconsiderations
Post Office Box 362025
Birmingham, AL 35236
Fax: 205-220-9560
Personal Choice Network Patient Educational Materials

Various educational materials are available to help the patient better understand their benefits and the referral process. The following items are available and are either mailed to the patient or provided to the PCP office to give to the patient:

- Alabama Personal Choice Marketing Brochure - Includes highlights of Alabama Personal Choice, how to select a PCP, enrollment information and commonly asked questions. This brochure is available in English and Spanish.

- Personal Choice Fact Sheet for the physician office.

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<thead>
<tr>
<th>Important Telephone Numbers</th>
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</thead>
<tbody>
<tr>
<td>PCN Provider Customer Service</td>
<td>1-877-231-7239</td>
</tr>
<tr>
<td>PCN Dedicated Telephone Line (Network Services)</td>
<td>1-866-904-4130 or 205-220-7200</td>
</tr>
<tr>
<td>PCN Fax Number</td>
<td>205-220-5763 or 1-800-303-8930</td>
</tr>
<tr>
<td>eSolutions Services (EDI)</td>
<td>205-220-6899</td>
</tr>
<tr>
<td>Blue Cross and Blue Shield of Alabama’s website</td>
<td>AlabamaBlue.com</td>
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