BLUE ADVANTAGE

Provider Manual

Blue Advantage®
A Medicare Approved PPO

PRV20221-2412

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Introduction

Blue Cross and Blue Shield of Alabama contracts 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 have been made for specialty care outside of the coverage area when necessary and for emergency and urgent needs, such as dialysis.

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 a special enrollment period.

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).

Appointment Wait Time Standards

Blue Cross providers in the primary care and behavioral health specialties must be accessible to Blue Advantage members. Per CMS guidance, members must get an appointment scheduled within a minimum number of days of their request.

Primary Care and Behavioral Health Services	Minimum Standards for Appointment Wait Times
Urgently needed services or emergency	Immediately
Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within 7 business days
Routine and preventive care	Within 30 business days

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 via web portal, eConnectivity or 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 payee NPI, individual NPI and Tax ID
- Missing, incorrect or invalid modifier
- Missing or incorrect quantity billed
- Incorrect physical address

Do I file claims to Medicare?

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

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

All providers should bill for services rendered using their NPI.

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 Combating Medicare Parts C and D Fraud, Waste and Abuse training annually**. In addition, we recommend that you review the Medicare Provider Compliance Tips on CMS' website.

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.

Data Breach Incident Reporting

In the event of a system compromise of a hospital and/or medical practice's network environment or data, the hospital and/or practice must immediately report to Blue Cross, but no more than 48 hours after becoming aware of the incident.

System compromise refers to any unauthorized access, breach or incident that results in unauthorized access, use or disclosure of protected health information (PHI) as defined under the HIPAA Privacy Rule. The hospital must notify the HIPAA Privacy Toll-free Help Line by calling **1-877-668-7222** or emailing ComplianceNotify@bcbsal.org and SecurityAwareness@bcbsal.org. In order to ensure proper risk management of system connections and to enact alternate operation support processes, the hospital must fully cooperate with Blue Cross to assess and respond to the compromise. This includes the necessary information, documents and assistance to fully mitigate any risks.

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 Audit Reports
- Claims Entry
- Claim Status
- Interactive HR360
- Interactive Patient Health Snapshot
- Member Eligibility and Benefits
- Payment History
- Pre-Service Reviews
- Referrals
- Remittances

Getting Started with EDI/eSolutions:

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

Fraud, Waste and Abuse

Blue Cross is committed to protecting the integrity of our Medicare Advantage product by preventing, detecting and investigating fraud, waste and abuse (FWA).

- **Fraud:** This includes any type of intentional deception or misrepresentation made with the knowledge that the deception could result in unauthorized benefit to the person committing it or any other person.
- **Waste:** This includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** Examples include when healthcare providers or suppliers do not follow good medical practices that result in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

If you suspect someone of committing fraud waste or abuse, there are several ways you can refer it for investigation:

- Complete the Report Suspected Fraud and Abuse form.
- Call our toll-free hotline at 1-800-824-4391.

You can remain anonymous when reporting healthcare fraud and abuse.

CMS' website offers numerous resources, including fraud prevention training materials, that can be found using the search term "fraud." Additionally, our Fraud and Abuse webpage includes educational information that can educate providers and patients.

Health and Clinical Engagement

The mission of our Blue Advantage team is to support our members' goals for health across physical, mental and social spheres. Managing members in the Member Management and Utilization Management programs is critical to:

- Improving quality of care
- Reducing readmissions
- Controlling costs
- Promoting self-management

Member assistance is provided in order to improve the healthcare experience, remove medical and social barriers and find solutions to support members' self-management of their own health. The Health and Clinical Engagement division is dedicated to providing programs and services to help optimize health and improve the quality of care for our members.

Our multidisciplinary Medicare Advantage team is integral to the success in improving our members' health as well as complex medical management efforts. Our team consists of medical directors, registered nurses, licensed social workers, pharmacists, and advocates who work collaboratively to deliver a holistic approach to supporting the member.

Our interactive Patient Health Snapshot displays any potential Health and Clinical Engagement programs for which the member is eligible. Member Services 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.

Health Risk Assessments and Wellness Visits

Health Risk Assessments (HRA) are important for capturing your Blue Advantage patients' full picture of health, including their chronic conditions and medications. The assessments are often performed during the patients' wellness visits.

Providers can complete the HR360 form during any encounter, but it is encouraged as part of the Annual Wellness Visit (AWV).

Blue Cross Network Providers who perform wellness visits (see specific impacted codes below) for Blue Advantage members are encouraged to complete and submit an accompanying HR360 to Blue Cross.

Welcome to Medicare	
HCPCS	**Description**
G0402	Initial Preventive Physical Examination (IPPE) – first 12 months of enrollment into Medicare Part B

Annual Wellness Visit (AWV)	
HCPCS	**Description**
G0438	Annual Wellness Visit (AWV), Initial – Includes a personalized prevention plan of service (PPS) – after the first 12 months of enrollment
G0439	Annual Wellness Visit (AWV), Subsequent – Includes a personalized plan of service (PPS)

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 through their vendor using the 270/271 transaction or through *ProviderAccess* Eligibility and Benefits. 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, 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 our Medical Policies 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.

To qualify, members must have three of the following chronic conditions: chronic obstructive pulmonary disease (COPD); osteoporosis; diabetes; chronic heart failure (CHF); or dyslipidemia (high cholesterol).

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 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.

Utilization Management

We use Utilization Management (UM) to monitor the appropriateness of healthcare services to our members and to help ensure members get the most out of their healthcare dollars. Our UM program involves review of services before, during and after the services are performed. For more information about UM, contact Provider Customer Service at 1-877-231-7239.

Here are some scenarios that may be encountered during the UM process that may require special consideration:

Changes in procedure/service codes

Verify benefits to determine next steps for advanced imaging, behavioral health, genetic testing and Part B Drug requests. For all other approvals issued, or an update to the code, a new review may be needed. For more information about UM, contact Provider Customer Service at 1-877-231-7239.

Medical necessity approval for acute inpatient stays (medical)

Scenario: Patient admits as inpatient for medical reasons (excludes elective procedures) and discharges 2 – 3 days later prior to medical necessity approval.

Through *ProviderAccess*, send in the request for medical necessity approval prior to claim submission for the medical necessity determination..

> **Note:** Some elective procedures need a determination prior to services being rendered. Through *ProviderAccess*, verify benefits and the code needed for medical necessity.

No insurance at time of hospitalization

Blue Cross will allow retrospective medical necessity review for services rendered in which the Beneficiary failed to provide insurance coverage information during the hospital stay. Through *ProviderAccess*, send in the request for medical necessity approval prior to claim submission for the medical necessity determination.

Member Appeals and Grivances (Medical)

Blue Advantage members have the right to file grievances and appeals within a certain timeframe for reconsiderations of disputes regarding determinations made by Blue Cross. Members are provided with information describing these rights upon enrollment and in denial determination letters.

Appeals	
Review Type	**Processing Time Frame**
Expedited (All Review Types)	72 hours
Standard Pre-Service	30 Days
Standard Post-Service	60 Days
Part B Drugs	7 Days

Contact Customer Service to resolve claim issues.

Potentially Noncovered Services and FAQs

Sign in to *ProviderAccess* to initiate a Pre-Service Organization Determination.

> **Note:** Certain procedures require precertification if they are performed inpatient. Use the pre-service lookup tool to verify if precertification is required for the procedure taking place.

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.

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). Use *ProviderAccess* 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.

Note: For a list of specific Pre-Service Organization Determination services go to the specific service listed on the Blue Advantage Network page under Pre-service Organization Determination.

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.
- Part B Drugs have a 24-hour expedited turnaround time and 72-hour standard turnaround time.

Blue Advantage Part B Drugs Predeterminations and Appeals Processing Time Frames:

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

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 the Provider Solutions Center 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?

Providers who fail to meet certain thresholds risk losing Blue Advantage network status as well as Select status in the Primary Care Select Program.

- Moderate-risk 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. Providers who have opted out of or have been excluded or precluded from the Medicare program are not eligible.

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.

Is there 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 at AlabamaBlue.com/findadoctor.

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

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

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 and Clinical Engagement/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**

Social Determinants of Health

Social determinants of health (SDOH) can greatly impact a patient's health and quality-of-life depending on the factors of their environment. SDOH can be reported by anyone from the patient's care team, such as providers, nurses, social workers, case managers, community health workers and patient navigators. They can be captured while completing the HR360 or during any encounter. Patients can also self-report any SDOH.

Once the SDOH are documented in the medical record, the appropriate Z codes can be applied for data collection. The patient's care team can use this data to:

- Improve the patient's quality of care
- Enhance care coordination
- Implement social needs interventions based on identified community needs

ICD-10 Code	Description
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

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.

Plans are rated on a scale of one to five stars: One star represents poor performance and five stars represents excellent performance. CMS releases Star Ratings annually, and these ratings reflect the experiences of patients enrolled in Medicare Advantage plans. Blue Advantage's success contributes to provider incentive opportunities, enhanced member benefits, and keeping member premiums low.

A Medicare health plan's rating is based on categories that include:

- Staying healthy, screenings, tests and vaccines
- Managing chronic (long-term) conditions
- Member experience with the health plan
- Member complaints, problems getting services and improvement in the health plan's performance
- Health plan customer service

A Medicare drug plan's rating is based on measures in four categories:

- Drug plan customer service
- Member complaints, problems getting services and improvement in the health plan's services
- Member experience with the drug plan
- Patient safety and accuracy of drug pricing

Measures in both groups of these categories are used to rate Medicare Advantage health plans. Annually, CMS sets the thresholds for each measure. CMS uses risk adjustment to predict the cost and use of healthcare services for members in the Blue Advantage product. CMS provides payments to healthcare plans at the member level for Medicare Advantage based on the health status of a member through risk scoring. The payments received are used to pay healthcare cost and administrative expenses, and offer programs aligned to complex patient care. It is important for providers to ensure all chronic health conditions are documented yearly in patient medical records according to CMS guidelines to ensure appropriate risk scores are assigned by CMS.

Subrogation

Blue Advantage contains a subrogation and reimbursement provision. Subrogation is the substitution of one party for another when the injured party has a legal claim against another party. It allows Blue Cross to recover from any other payer the cost of our healthcare benefits.

In general, we have the right to recover the cost of a member's medical care, to the extent of what we have paid, from anyone the member has the right to recover from, or to substitute for the member and seek to recover our payment. For example, if automobile or liability insurance is involved, Blue Cross will pay for the services rendered as the primary payer according to the contract. If payment is made to the physician's office by both Blue Cross and insurance other than another health plan, Blue Cross should be notified of the overpayment. We will then request the overpayment from the physician's office, if needed.

In all instances, providers should contact Provider Customer Service so that they may check the contract and advise to whom the refund should be sent.

Timely Filing Guidelines

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

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.

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

Blue Advantage
A Medicare Approved PPO

PRV20221-2412