

Blue Cross Medicare Advantage (HMO/DSNP)SM

Supplement

to the Blue EssentialsSM

Blue PremierSM,

Blue Advantage HMOSM and

MyBlue HealthSM

Provider Manual



Revised 08-26-24

HMO plans are provided by Blue Cross and Blue Shield of Texas, which refers to GHS Insurance Company, an Independent Licensee of the Blue Cross and Blue Shield Association, GHS is a Medicare Advantage organization with a Medicare contract. Enrollment in GHA plans depends on contract renewal.

Blue Cross Medicare Advantage (HMO/DSNP) Provider Manual Supplement

Table of Contents	Page
Overview	
• Introduction	6
• The Blue Cross Medicare Advantage HMO Network	6
• The Blue Cross Medicare Advantage HMO SNP Network	7
General Information	
• ID Cards, Eligibility and Benefits	9
• Sample HMO ID Card	10
• Sample HMO SNP ID Card	11
• ID Card Copayment Information	12
• Verification of How a Particular Service Will Be Paid	12
• Lab Provider – Quest Diagnostics	13
• Addresses for Claims Filing & Customer Service Phone Numbers	14
• Benefit or Traveler Benefit	14
• Medical Records	15
• 24-Hour Coverage	15
• Emergency Services Definition	16
• Emergency Medical Conditions	16
• Emergency Care	17
• eViCore®	17
• Out-of-Area Renal Dialysis Services	18
• Preventive Services	18
• Inpatient Hospital Admissions	19
• Behavioral Health Services	19
Roles and Responsibilities	
• Role of the Primary Health Care Provider	21
• Panel Closure	25
• Backup PCPs	25
• Referrals to Specialty Care Health Care Providers are not required	26
• Role of the Specialty Care Health Care Provider	27
• Specialist as a Primary Health Care Provider	29
Claim Information	
• Claims Process	30
• Claim Submission Information	31
• Duplicate Claims	32
• Coordination of Benefits	32
• Claim Disputes	32
• Process Used to Recover Overpayments on Claims	33
• Balance Billing	33
• Nondiscrimination	34
• Confidentiality	34
• Basic Rule	34

Blue Cross Medicare Advantage (HMO/DSNP) Provider Manual Supplement

Table of Contents	Page
• Uniform Benefits	36
• Benefits During Disasters and Catastrophic Events	36
• Access and Availability Rules	36
• Cost-Sharing for In-Network Preventive Services	38
• Drug Coverage	39
• Medical Supplies Associated with the Delivery of Insulin	40
• Clinical Trials	40
• Advance Directives	40
Performance and Compliance Standards – Utilization Management	
• Medical Necessity	41
• Medical Policy	42
• Prior Authorization Requirements List	43
• Inpatient Prior Authorization	43
• Availity® Authorizations & Referrals	44
• Concurrent Hospital Review	45
• Discharge Planning	45
Performance and Compliance Standards – Case Management	
• Care Coordination	46
• Initial Health Risk Assessment	46
• Annual Health Assessment	47
• Annual Wellness Visit Resources	47
Performance and Compliance Standards – Quality Improvement	
• Quality Improvement Program	48
• Quality of Care Issues	49
• Center for Medicare and Medicaid Services Star Ratings	50
• Cooperation	51
• Utilization Management Program	51
• Specialty Care Health Care Provider	52
• Health Care Provider Responsibilities	52
• 30 Day Readmissions	53
Care Management	
• Care Management	54
• Second Medical or Surgical Opinion	56
• Clinical Review Criteria	56
• Health Risk Assessment	57

Blue Cross Medicare Advantage (HMO/DSNP) Provider Manual Supplement

Table of Contents	Page
• Disease Management Programs	58
Health Care Providers Performance Standards and Compliance Obligations	
• Evaluating Performance of Participating Health Care Providers	59
• Health Care Provider Compliance to Standards of Care	60
• Laws Regarding Federal Funds	62
• Marketing	62
• Sanctions under Federal Health Programs and State Law	62
Selection and Retention of Participating Health Care Providers	
• Participation Requirements	63
• Credentialing & Recredentialing of Participating Health Care Providers	63
• Credentialing & Recredentialing of Institutional Providers	63
• Appeal Process for Health Care Provider Participation Decisions	64
• Notification to Members of Health Care Provider Termination	64
Medical Records	
• Medical Record Review	65
• Standards for Medical Records	65
• Advance Directive	65
• Confidentiality of Member Information	65
Reporting Obligations	
• Cooperation in Meeting CMS Requirements	66
• Certification of Diagnostic Data	66
Initial Decisions, Appeals and Grievances	
• Initial Decisions	67
• Appeals and Grievances	69
• Appeals Address and Claim Inquiries Phone Number	69
• Resolving Grievances/Complaints	69
• Resolving Appeals	70
• Further Appeal Rights	72
• Participating Health Care Provider Obligations – Organization Determinations	72
• Participating Health Care Provider Obligations – Appeals	73
Member Rights and Responsibilities	
• Rights	74
• Responsibilities	76
• Member Satisfaction	77

Blue Cross Medicare Advantage (HMO/DSNP) Provider Manual Supplement

Table of Contents	Page
• Services Provided in a Culturally Competent Manner	77
• Advance Directive	77
• Member Complaints/Grievances	77
Obligation to Provide Access to Care	
• Member Access to Health Care Guidelines	78
• Health Care Provider Availability	78
• Health Care Provider Confidentiality Statement	79
• Prohibition Against Discrimination	79
Glossary of Terms	80
Blue Cross Medicare Advantage HMO Provider Quick Reference Guide	83
• Key Contacts List	83
Disclaimers	84

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Overview

Introduction

Blue Cross Medicare Advantage HMO is pleased to welcome you as a Participating health care provider. The **Blue EssentialsSM, Blue Advantage HMOSM, Blue PremierSM and MyBlue HealthSM Provider Manual** plus this Provider Manual Supplement explain the policies and procedures of the **Blue Cross Medicare Advantage HMO** network. We hope it provides you and your office staff with helpful information as you service our members. The information is intended to provide guidance to your office while participating in **Blue Cross Medicare Advantage HMO**. This Provider Manual Supplement is applicable only to the operation of **Blue Cross Medicare Advantage HMO**.

The Blue Cross Medicare Advantage HMO Network

Blue Cross Medicare Advantage HMO is a Medicare Advantage Plan. **Blue Cross Medicare Advantage HMO** maintains and monitors a network of participating health care providers including physicians, professional providers, hospitals, skilled nursing facilities, ancillary providers and other providers through which members obtain Covered Services. Participating health care providers are encouraged to coordinate care on behalf of their patients.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Overview

Blue Cross Medicare Advantage HMO SNPSM is a coordinated care special needs plan specifically designed to provide targeted care and limited enrollment to special needs individuals who are eligible for both Medicare *and* Medicaid. The plan is an integrated care model used to improve the health of our most vulnerable members. Additionally, the Model of Care is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan are identified and addressed. The Center for Medicare and Medicaid Services requires all contracted and out-of-network providers seen by members on a routine basis to receive training on the SNP MOC.

DSNP Training for Providers and Staff

1. All DSNP State Plans will need to provide ongoing staff training and provider training on the DSNP Model of Care. This can occur through live in-person training sessions as well as WebEx or Computer-based Training Modules.
2. Training must occur at least annually for providers and internal staff and will be ongoing for staff as needed.
3. A provider can submit an attestation indicating that they have completed the DSNP Model of Care Training.

SNP MOC Goals

1. Improve beneficiary outcomes
2. Integrate and coordinate care
3. Ensure use of preventive health services
4. Improve management of chronic disease through goal setting
5. Improve access to affordable care

Cost Sharing Protections for Dual Eligible Members

CMS Notification Network Providers (effective 2022):

1. Must not hold a Dual Eligible Member liable for the Cost Sharing Obligations; and
2. Must accept as payment in full the medicare plan and/or provider may submit claim to Medicaid plan for cost sharing. Provider cannot bill the member.

Medicare Advantage DSNP Trainings

[Blue Cross Medicare Advantage Dual Care \(HMO SNP\) Model of Care Training](#)

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

**The Blue
Cross
Medicare
Advantage
HMO
Network,
cont'd**

Overview

Blue Cross Medicare Advantage HMO and HMO SNP will market its Medicare Advantage Plans to eligible individuals for Medicare Parts A and B that live in the following approved Service Area in the state of Texas:

Blue Cross Medicare Advantage (HMO SNP) Service Areas for 2025: Adding Childress county

Blue Cross Medicare Advantage (HMO SNP) Service Areas for 2024:

Anderson, Andrews, Aransas, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Bastrop, Baylor, Bee, Bell, Bexar, Blanco, Borden, Bosque, Bowie, Brazoria, Brazos, Brewster, Briscoe, Brooks, Burleson, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Cass, Castro, Chambers, Cherokee, Clay, Cochran, Coke, Coleman, Collin, Colorado, Comal, Concho, Cooke, Coryell, Crane, Crosby, Culberson, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dewitt, Dickens, Dimmit, Donley, Duval, El Paso, Ellis, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Fort Bend, Franklin, Freestone, Frio, Gaines, Galveston, Garza, Gillespie, Glasscock, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hardeman, Hardin, Harris, Harrison, Hartley, Haskell, Hays, Henderson, Hidalgo, Hill, Hockley, Hood, Hopkins, Houston, Howard, Hudspeth, Hutchinson, Irion, Jack, Jackson, Jeff Davis, Jefferson, Jim Hogg, Jim Wells, Johnson, Karnes, Kaufman, Kendall, Kenedy, Kent, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamar, Lamb, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Live Oak, Llano, Loving, Lubbock, Lynn, Madison, Marion, Martin, Mason, Matagorda, Mcculloch, Mclennan, McMullen, Medina, Menard, Midland, Milam, Mills, Mitchell, Montague, Montgomery, Moore, Morris, Motley, Nacogdoches, Navarro, Nueces, Oldham, Orange, Palo Pinto, Panola, Parker, Pecos, Polk, Potter, Presidio, Rains, Randall, Reagan, Real, Red River, Reeves, Refugio, Roberts, Robertson, Rockwall, Runnels, Rusk, San Augustine, San Jacinto, San Patricio, San Saba, Schleicher, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Terry, Throckmorton, Titus, Tom Green, Travis, Trinity, Tyler, Upshur, Upton, Van Zandt, Victoria, Walker, Waller, Washington, Webb, Wharton, Willacy, Williamson, Wilson, Winkler, Wise, Wood, Yoakum, Young, Zapata, Zavala

Blue Cross Medicare Advantage HMO and HMO SNP will furnish members with a Member Handbook and Evidence of Coverage that will include a summary of the terms and conditions of its plan.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information

ID Cards, Eligibility and Benefits

Each **Blue Cross Medicare Advantage HMO and SNP** member will receive a **Blue Cross Medicare Advantage HMO or HMO SNP** identification card containing the member's name, member ID number, and information about their benefits.

At each office visit, your office staff should:

- Ask for the member's ID card
- Copy both sides of the member's ID card and keep the copy with the patient's file
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- Refer to the member's ID card for the appropriate telephone number to verify eligibility of **Blue Cross Medicare Advantage HMO or HMO SNP** deductibles, coinsurance amounts, copayments, and other benefit information
- Check eligibility and for other relevant information
- [Member ID Cards](#) will show designated Primary Care Providers name on the front of the card.

Sample ID Cards are located on pages 10 and 11


Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd



Sample ID Card (front & back)

Sample HMO ID Card

FRONT

	 BlueCross BlueShield of Texas	Blue Cross Medicare Advantage (HMO)
3-Character Prefix	Name: Member Name ID: ZGJ804123456	HMO Plan Identifier
	Office Visit: Copay Specialist: Copay Emergency Room: Copay	
	Plan: Blue Cross Medicare Advantage Basic (HMO) RxBin: RXBIN RxPCN: RXPCN RxGrp: RX_GROUP RxID: 804123456	Plan (80840): 9101000260 PCP: PCP Name PCP Phone #: PCP PHONE
	SAMPLE	
	HS133 001 005	MEDICARE ADVANTAGE HMO MedicareRx <small>Prescription Drug Coverage</small>

BACK

getbluetx.com/mapd SAMPLE	
	
Submit Medical Claims to: <<XW_SUBMIT_TO>> <<XW_ADDRESS>> <<XW_CITY>> <<XW_ST>> <<XW_ZIP>> Out of State Provider: File medical claims with your local BCBS plan. The member only has urgent/emergency benefits outside of TX.	Customer Service: 1-877-774-8592 Pharmacy Line: 1-877-277-7898 TTY: 711 Nurse Advice Line: 1-800-631-7023
 BlueCross BlueShield of Texas	
HMO plans provided by Blue Cross and Blue Shield of Texas, which refers to HCSC Insurance Services Company (HISC) and GHS Insurance Company (GHSIC). HCSC, HISC and GHSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC, HISC and GHSIC are Medicare Advantage organizations with a Medicare contract.	

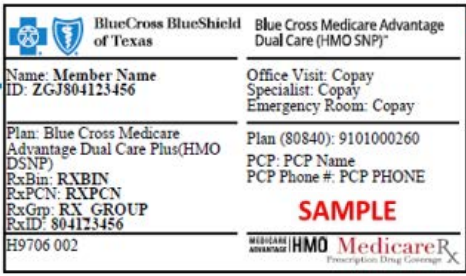
Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

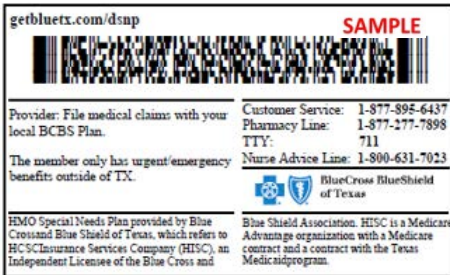
Sample ID Card (front & back)

SAMPLE HMO SNP ID CARD

FRONT

<div style="border: 1px solid blue; padding: 2px;">3-Character Prefix</div>	<div style="border: 1px solid blue; padding: 2px;">HMO SNP Plan Identifier</div>	
		

BACK



Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

ID Card Copayment Information

- The office visit copayment (in-network) or coinsurance (out-of-network) is determined by how a health care provider is contracted with **Blue Cross Medicare Advantage (HMO)**.
- If the physician is contracted for **Blue Cross Medicare Advantage (HMO)** as a PCP, the health care provider should collect the in-network copayment indicated on the member ID card for the PCP.
- If the health care provider is contracted for **Blue Cross Medicare Advantage (HMO)** as an in-network Specialty Care Physician or Professional Provider, the health care provider should collect the in-network copayment indicated on the member ID card for Specialists.
- If the health care provider is contracted as a Primary Care Physician and a Specialty Care Physician, then the health care provider should collect the PCP in-network copayment indicated on the member ID card.
- If the health care provider is out of network, contact the Customer Service number listed on the member's ID card to determine the patient's cost share. **NOTE:** BCBSTX strongly encourages providers to check patient eligibility and benefit information prior to every scheduled appointment. Refer to the back of the member's ID card for the Customer Service phone number or check benefits through Availity or your preferred Web vendor.

Verification of How a Particular Service Will Be Paid

Under the Prompt Pay Legislation, providers of service have the right to request verification that a particular service will be paid by the insurance carrier. Verification as defined by the Texas Department of Insurance is a guarantee of payment for health care or medical care service if the services are rendered within the required timeframe to the patient for whom the services are proposed.

Refer to section B of the "[Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual](#)" which can be found on bcbstx.com/

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

**Blue Cross
Medicare
Advantage
HMO Only Lab
Provider –
Quest
Diagnostics,
Inc.**

Quest Diagnostics, Inc. is the **preferred** outpatient clinical reference laboratory provider for **Blue Cross Medicare Advantage HMO** members.

Note: *This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free standing ambulatory surgery centers).*

Quest Diagnostics Offers:

- On-line scheduling for Quest Diagnostics' Patient Service Center locations. To schedule a PSC appointment, log onto www.QuestDiagnostics.com/patient or call **1-888-277-8772**.
- Convenient patient access to over 150 PSCs.
- 24/7 access to electronic lab orders, results, and other office solutions through *Care360® Labs and Meds*.

For more information about Quest Diagnostics lab testing solutions or to setup an account, contact your Quest Diagnostics' Physician Representative or call **1-866-MY-QUEST**.

Reminder of CLIA Requirements

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

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

**Addresses
for Claims
Filing &
Customer
Service
Phone
Numbers**

The member's ID card provides claims filing and customer service information. If in doubt, please call **Blue Cross Medicare Advantage HMO** Provider Customer Service at the numbers listed below. Although the submission of claims electronically is the preferred method, when a paper claim is submitted for a member with a PCP not affiliated with a capitated Independent Practice Association or Medical Group, use the appropriate address indicated below.

Plan/Group	Claims and Refunds Filing Address
Blue Cross Medicare Advantage HMO Provider Customer Service: 1-877-774-8592	Blue Cross Medicare Advantage HMO c/o Provider Services PO Box 3686 Scranton, PA 18505 - 9998

**Benefit or
Traveler
Benefits**

When the member is continuously absent from the service area for more than six months, they may be disenrolled from the plan. We offer as a supplemental benefit a visitor/traveler program in the U.S., which will allow the member to remain enrolled in our plan when the member is outside of our service area for up to 6 months. This program is available to all Blue Cross Medicare Advantage members who are temporarily in the visitor/traveler area. Under our visitor/traveler program you may receive all plan Medicare-covered services at in-network cost sharing when the member notifies the plan in advance of their travel. Members are encouraged to contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

Medical Records

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

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

24-Hour Coverage

Participating physicians and professional providers are required to provide coverage for **Blue Cross Medicare Advantage HMO** members 24 hours a day, 7 days a week. When a participating health care provider is unavailable to provide services, the participating health care provider must ensure that he or she has arranged for coverage from another participating health care provider. The member must have the ability to leave a message and receive a return call within 30 minutes, or the provider must have an answering service to relay urgent calls to providers attention after hours. Hospital emergency rooms or urgent care centers are not substitution for covering participating health care providers. Participating health care providers can consult their **Blue Cross Medicare Advantage HMO** Provider Directory to identify health care providers participating in the **Blue Cross Medicare Advantage HMO** network. You may also contact the **Blue Cross Medicare Advantage HMO** Provider Customer Service Department at the number listed on the back of the member's ID card with questions regarding which health care providers participate in the **Blue Cross Medicare Advantage HMO** network.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

Emergency Services Definition

Emergency Services are inpatient or outpatient services:

- By a provider qualified to furnish Emergency Services
- Needed to evaluate or stabilize an Emergency Medical Condition.
- Are when the member, or any other prudent layperson with an average knowledge of health and medicine, believes that the member has medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.

Emergency Medical Conditions

Emergency Medical Conditions is a medical condition of immediate onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Emergency Care

Emergency Care services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical conditions of immediate onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement

Emergency Care services necessary to evaluate and stabilize an Emergency Medical Condition are covered by **Blue Cross Medicare Advantage HMO**. Members with an Emergency Medical Condition should be instructed to go to the nearest Emergency Provider. Evaluation and stabilization of an Emergency Medical Condition in a hospital or comparable facility does not require prior authorization. Providers need to notify the UM department of inpatient admissions for post stabilization care services within one (1) business day of the admission following treatment of an emergency medical condition for Medicare Advantage HMO members. Failure to timely notify BCBSTX and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX. Emergency Care services will be covered at the in-network benefit level.

eviCore®

BCBSTX as contracted with [eviCore healthcare](#) to provide certain utilization management prior authorization services. Services requiring prior authorization as well as information on how to prior authorize services with eviCore are outlined on the [Utilization Management](#) page and on the [eviCore](#) page on our provider [website](#).

Services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment, and the rendering provider may not seek reimbursement from the member.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

Out-of-Area Renal Dialysis Services

A member may obtain medically necessary dialysis services from any qualified health care provider the member selects when the member is temporarily absent from the **Blue Cross Medicare Advantage HMO** Service Area and cannot reasonably access **Blue Cross Medicare Advantage HMO** dialysis health care providers. Prior authorization is not required.

Note: Pre-notification from the member is recommended in order for the member's case manager to follow-up with the member to ensure member follow-up care. A member may voluntarily advise **Blue Cross Medicare Advantage HMO** when they will temporarily be out of the Service Area. Blue Cross Medicare Advantage HMO can assist the member in locating a qualified dialysis health care provider.

Preventive Services

Members may access the following services directly from any applicable participating health care provider. Some examples are:

- Screening mammograms
- Annual routine vision exams
- Glaucoma screening
- Hearing screening
- Influenza or pneumococcal vaccinations (*Members are not charged a copayment for influenza or pneumococcal vaccinations*)
- Routine and preventive women's health services (such as pap smears & pelvic exams)
- Bone mass measurements
- Colorectal screening exams
- Prostate cancer screening exams
- Cardiovascular disease screening
- Diabetes screening
- Diabetes self-management training
- Medical nutritional therapy
- Smoking cessation
- Annual physical exam
- Abdominal Aortic Aneurysm Screening for high-risk individuals.

Access CMS Medicare Learning Network® [Medicare Preventive Services](#) for detailed information on Medicare Preventive Services.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

Inpatient Hospital Admissions

All inpatient hospital admissions require prior authorization from the **Blue Cross Medicare Advantage HMO** Utilization Management Department. The prior authorization process for admissions is carried out by the admitting health care provider or hospital personnel.

In addition, providers need to notify the UM department of inpatient admissions for post stabilization care services within one (1) business day of the admission following treatment of an emergency medical condition for Medicare Advantage HMO members. **Failure to timely notify BCBSTX and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post-stabilization care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX.**

Additionally, when a **Blue Cross Medicare Advantage (HMO)** member arrives at the facility for an elective admission, providers should notify the BCBSTX UM department to assist in patient care coordination.

Admitting health care providers are responsible for contacting the Utilization Management Department to request prior authorization for additional days if an extension of the approved length of stay is required. The admitting health care provider will provide appropriate referrals for extended care. Blue Cross Medicare Advantage UM personnel will assist with coordinating all services identified as necessary in the discharge planning process.

Behavioral Health Services

Blue Cross Medicare Advantage HMO members requiring Behavioral Health Services (Mental Health and Chemical Dependency) are required to call BCBSTX Behavioral Health at **1-877-774-8592**.

Telephonic access is available 24 hours a day, 7 days a week.

The Care Managers will provide:

- Prior authorization services for hospital admissions and outpatient care
- Referral services, if required
- Case Management
- Assistance in the selection of a participating health care provider
- Crisis Intervention

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

Behavioral Health Services, cont'd

The following procedures apply to behavioral health services and require authorizations:

Inpatient Levels of Care

- Inpatient Mental Health
- Inpatient Substance Abuse
- Partial Hospital Program

Outpatient Levels of Care/Services

- Intensive Outpatient Program
- Outpatient Program Substance Abuse
- Electro-Convulsive Therapy
- Psychological Testing

Note: *Services must be Medically Necessary before a prior authorization number is issued. Claims received that do not have a prior authorization number for a hospital admission or outpatient care will be denied.*

Blue Cross Medicare Advantage HMO behavioral health professionals or physicians may not seek payment from the member when a claim is denied for lack of a prior authorization number.

The call for prior authorize can be made by the member, the behavioral health professional, physician or authorized care taker.

Behavioral health professionals and physicians are encouraged to admit patients to a participating facility unless an emergency situation exists that precludes safe access to a participating facility or if the admission is approved for a non-participating facility.

The member will only receive in-network benefits when services are performed at a **participating Blue Cross Medicare Advantage HMO** facility unless the admission is approved for a non-participating facility.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

General Information, cont'd

Behavioral Health Services, cont'd

Behavioral Health Claims Filing Address	Payor ID
Blue Cross Medicare Advantage HMO Claims Payment Request: PO Box 4195 Scranton, PA 18505	837P - Professional: 66006 837I - Institutional: 66006

Role of the Primary Care Health Care Provider

Roles and Responsibilities

The member must contact his/her Primary Care health care provider (family practice physician, general practice physician, internal medicine physician, advanced nurse practitioner, physician assistant, obstetrics & gynecology physician)* for all of their health care needs. The member's chosen PCP will be indicated on the front of the member's ID card.

*Please Note: An obstetrics & gynecology physician can choose to be a Primary Care Physician or a Specialty Care Physician. If the obstetrics & gynecology physician chooses to be a PCP and the **Blue Cross Medicare Advantage HMO** member chooses the obstetrics & gynecology physician as their PCP then the obstetrics & gynecology physician must assume and meet all of the **PCP** roles and requirements indicated on Section B "Provider Roles and Responsibilities" in the below Plan manual:

[Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health – Provider Manual.](#)

Each Primary Care health care provider is responsible for making his/ her own arrangements for patient coverage when unavailable.

A health care provider who has contracted with **Blue Cross Medicare Advantage HMO** as a PCP will agree to render services to the **Blue Cross Medicare Advantage HMO** member primary, preventive, acute and chronic health care management and:

- Provide the same level of care to **Blue Cross Medicare Advantage HMO** patients as provided to all other patients.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Roles and Responsibilities, cont'd

Role of the Primary Care Health Care Provider

- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week. PCPs should have a verifiable mechanism in place for immediate response for directing patients to alternative after hours care based on the urgency of the patient's needs. Acceptable mechanisms may include: an answering service that offers to call or page the physician; a recorded message that directs the patient to call the answering service with the provided phone number.
- Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
- Meet required Patient Appointment Access Standards (*for more detail refer to Section G - Quality Improvement Program*):
 - Emergency Care - perform immediate triage during office hours and have a method for directing patients to alternative care after hours.
 - Urgent Care - Immediately.
 - Symptomatic Non-Urgent Care (Routine) - within 5 business days.
 - Annual Physical Exam - within 30 business days.
 - Initial New Patient Visit - within 30 business days.
 - In-office Wait Time - within 30 minutes.
 - After Hours Access – immediate.
- Keep a central record of the member's health and health care that is complete and accurate.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Roles and Responsibilities, cont'd

**Role of the
Primary
Care Health
Care
Provider,
cont'd**

- Refer the **Blue Cross Medicare Advantage HMO** member to specialty care health care providers within the same Provider Network.
For Dental – Dental Networks of America -
call **1-800-972-7565**.
- *PCPs will assist with referrals to vision care providers for members with medical conditions.*
For Routine Vision – EyeMed Vision Care -
call **1-844-684-2255**
- Complete referral authorizations, outpatient prior authorizations and inpatient admissions by calling the Utilization Management Department number on the back of the member's card when applicable.
- Refer to the detailed information and instructions in Sections C & E of the [Blue Essentials](#), [Blue Advantage HMO](#), [Blue Premier](#) and [MyBlue Health Provider Manual](#) for more information on the Availity Authorizations & Referrals tool for referrals and prior authorizations.
- Provide copies of X-ray, laboratory results, and other health records to specialty care health care providers to enhance continuity of care and to prevent duplication of diagnostic procedures.
- Provide copies of medical records when requested by **Blue Cross Medicare Advantage HMO**.
- Enter into the **Blue Cross Medicare Advantage HMO** member's health record all reports received from SCPs.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Role of the Primary Care Health Care Providers, cont'd

Roles and Responsibilities,cont'd

- Assume the responsibility for obtaining prior authorization for hospital admissions in which the provider is the admitting health care physician or delegate this responsibility to the admitting specialty care health care providers.
- Assume the responsibility for care management as soon as possible after receiving information that a **Blue Cross Medicare Advantage HMO** member on his/her PCP list has been hospitalized in the local area on an emergency basis.
- Follow HIPPA guidelines when sharing any member PHI.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Roles and Responsibilities, cont'd

Panel Closure

Each **Blue Cross Medicare Advantage HMO** member shall select a PCP in accordance with the procedures set forth in the Membership Agreement. PCP's or Medical Group agree to accept **Blue Cross Medicare Advantage HMO** members who have selected or who have been assigned to the PCP. PCP or Medical Group must notify **Blue Cross Medicare Advantage HMO** that their practice is closed to new patients of **Blue Cross Medicare Advantage HMO**, as well as new patients of all other health plans. PCPs or Medical Group must give **Blue Cross Medicare Advantage HMO** at least ninety (90) days prior written notice of closing their practice to new **Blue Cross Medicare Advantage HMO** members.

Individual PCP or Medical Group agrees that **Blue Cross Medicare Advantage HMO** shall have no obligation to guarantee any minimum number of **Blue Cross Medicare Advantage HMO** members to Individual PCP or Medical Group and that Individual PCP or Medical Group shall accept all patients enrolling as **Blue Cross Medicare Advantage HMO** members.

Key Points:

- PCP may close practice with at least 90 days' prior written notice.

PCP may only close his/her practice to **Blue Cross Medicare Advantage HMO** members if they have at least 300 or more **Blue Cross Medicare Advantage HMO** members.

Back up PCPs

The PCP designates backup (covering) PCP during the network application process.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Roles and Responsibilities, cont'd

**Referrals to
Specialty
Care
Physicians or
Professional
Providers are
not required**

Referrals to SCPs are not required if **Blue Cross Medicare Advantage HMO** members receive medical care from a **Blue Cross Medicare Advantage HMO** participating physicians and professional providers.

A PCP may not refer to himself as a specialty care health care provider when treating a member who is already on his/her PCP list.

For more information on referrals and submitting via the Availity Authorizations & Referrals tool, refer to Sections C & D of the [Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual](#) and [Provider Tools](#) on the provider website.

If the SCP determines that a **Blue Cross Medicare Advantage HMO** member needs to be seen by another SCP, the **Blue Cross Medicare Advantage HMO** member must be referred back to the member's PCP.

Note: The SCP cannot refer to other SCP.

Exception: PCP or SCP have the ability to directly manage and coordinate a woman's care for obstetrical and gynecological conditions, including obtaining referrals through the Availity tool for obstetrical/gynecological related specialty care and testing to other **Blue Cross Medicare Advantage HMO** participating health care providers that participate in the same Provider Network as the member's PCP, as applicable.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Roles and Responsibilities, cont'd

Role of the Specialty Care Health Care Providers

A **Blue Cross Medicare Advantage HMO** participating health care provider who provides services as a specialty care health care provider is expected to:

- Provide the same level of care to **Blue Cross Medicare Advantage HMO** patients as provided to all other patients.
- Provide urgent care and emergency care or coverage of care 24 hours a day, seven days a week. SCPs have a verifiable mechanism in place, for immediate response directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician; a recorded message that directs the patient to call the answering service with the provided phone number, or a recorded message that directs the patient to call or page the physician with the provided phone number.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access Standards (*for more details refer to Section G – Quality Improvement Program in the Blue EssentialsSM, Blue Advantage HMOSM, Blue PremierSM and MyBlue HealthSM Provider Manual*).
 - Emergency Care – perform immediate triage during office hours and have a method for directing patients to alternative care after hours
 - Urgent Care – immediately
 - Symptomatic Non-Urgent Care (Routine) – within 7 business days
 - Initial New Patient Visit – within 30 business days
 - In-Office Wait Time – within 30 minutes
 - After Hours Access – immediate
- Keep a central record of the member's health and health care that is complete and accurate.
- Accept referrals for Blue Cross Medicare Advantage HMO members in accordance with the services and the number of visits requested by the PCP in the same Provider Network, if applicable.
- Report back to the PCP upon completion of the consultation/treatment.
- Provide copies of x-ray and laboratory results and other health record information to the member's PCP, as appropriate.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Roles and Responsibilities, cont'd

Role of the Specialty Care Health Care Providers, cont'd

- Coordinate inpatient care with the PCP so that unnecessary visits by other physicians or professional providers are avoided.
- The Medical Care Management IQMP staff will send notification of the approval, to include the effective date [first (1st) day of the month following the approved decision] to the member within 30 calendar days of receiving the request for special consideration.
- If the request for special consideration is denied by **Blue Cross Medicare Advantage HMO**, the medical director will send a denial letter within 30 days of receiving the request explaining the denial and the member's right to appeal the decision through the **Blue Cross Medicare Advantage HMO** Complaint Process.
- The effective date of the new designation of the non-primary care specialist will not be retroactive and may reduce the amount of compensation owed to the original PCP for services provided before the date of the new designation. For further details, contact Provider Customer Service for **Blue Cross Medicare Advantage HMO**, call **1-877-774-8592**.
- Cooperate with BCBSTX for proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, party liens and other third-party liability. BCBSTX contracted physicians agree to file claims and encounter information to BCBSTX even if the physician or professional provider believes or knows there is not any third-party liability.
- Only bill **Blue Cross Medicare Advantage HMO** members for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty care physicians or professional providers will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage.
- Use his/her best efforts to participate with BCBSTX Plan's Electronic Funds Transfer and Electronic Remittance Advice under the terms and conditions set forth in the EFT Agreement and as described on the ERA enrollment form.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Role of the Specialty Care Health Care Providers, cont'd

Roles and Responsibilities, cont'd

Additionally,

- For services requiring authorization, if additional services and/or visits are needed, beyond authorized by the PCP, a new authorization must be obtained from the PCP.
- If authorized by the PCP, arrange for the hospital admission of the **Blue Cross Medicare Advantage HMO** member into a participating Facility through the Utilization Management Department, and assume responsibility for completion of steps required by **Blue Cross Medicare Advantage HMO** to prior authorize the admission.

Specialist as a Primary Health Care Provider

Any Specialist providing medical services to a **Blue Cross Medicare Advantage HMO** member with a chronic, disabling or life-threatening illness may apply to the **Blue Cross Medicare Advantage HMO** Medical Director to be a specialty care health care provider as a PCP, provided that:

- The request for the specialty care health care providers includes certification of medical need, along with the applicable supporting documentation, and is signed by the **Blue Cross Medicare Advantage HMO** member or the specialty care health care provider interested in serving as the PCP.
- The specialty care health care provider must meet **Blue Cross Medicare Advantage HMO** requirements for PCP participation. Refer to Section B "Provider Roles and Responsibilities" in the [Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health –Provider Manual](#).
- The specialty care health care provider is willing to coordinate all of the member's health care needs and accept **Blue Cross Medicare Advantage HMO** reimbursement.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Claim Information

Claims Process

Participating physicians and professional providers must submit claims to **Blue Cross Medicare Advantage HMO** within **180** days of the date of service, using the standard claim form or electronically as discussed below. Services billed beyond **180** days from date of service are not eligible for reimbursement. **Blue Cross Medicare Advantage HMO** participating physicians and professional providers may not seek payment from the member for claims submitted after the **180th** day filing deadline.

To expedite claims payment, the following items must be submitted on your claims:

- Member's name
- Member's date of birth and sex
- Member's Medicare Advantage HMO ID number
- Individual member's policy number
- Indication of job-related injury or illness or accident-related illness or injury, including pertinent details
- ICD-10 Diagnosis Codes
- CPT[®] Procedure Codes
- Date(s) of service(s)
- Charge for each service
- Physician's or professional provider's Tax Identification Number
- Name/address of participating health care provider
- Signature of participating health care provider
- Place of Service Code
- National Provider Identifier (NPI) Number

Blue Cross Medicare Advantage HMO will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to Medicare Advantage HMO should comply with those requirements.

Claims will be paid at the lesser of (1) billed charges for services and (2) the amount due on the claim per the provider's contract terms. In no event will claims be paid greater than provider's billed charges.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Claim Information, cont'd

Claim Submission Information

Blue Cross Medicare Advantage HMO claims should be submitted as follows:

- **Blue Cross Medicare Advantage HMO** claims should be submitted electronically through the Availity for processing.
- **Blue Cross Medicare Advantage HMO** Electronic Payor ID#: **66006**

For information on electronic filing of **Blue Cross Medicare Advantage HMO** claims, contact the Availity Health Information Network at **1-800-282-4548**. **Blue Cross Medicare Advantage HMO** claims must be submitted within 180 days of the date of service. Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. **Blue Cross Medicare Advantage HMO** providers may not seek payment from the Member for claims submitted after the 180 days filing deadline.

Blue Cross Medicare Advantage HMO claims may be submitted:

- (1) electronically in the CMS National Standard Format or the current version of the ANSI 837 format, or
- (2) on a completed version of the applicable CMS-1500 claim form and mailed to:

**Blue Cross Medicare Advantage HMO
Medical Claims Payment Request**

**PO Box 4195
Scranton, PA 18505**

Blue Cross Medicare Advantage HMO claims (electronic & paper) must be filed with the member's complete ID number - exactly as shown on the member's ID card including the 3-character prefix **ZGJ**.

Blue Cross Medicare Advantage HMO claims containing adequate information and submitted in accordance with these guidelines will be paid within 45 days for paper claims and 30 days for electronic claims.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Duplicate Claims

Claim Information, cont'd

Providers submitting electronic claims for **Blue Cross Medicare Advantage HMO** members may experience duplicate claim rejections if claims are resubmitted within 90 days of a previously processed claim that includes the exact data for the same patient and date(s) of service. However, duplicate claim rejections should not occur if the following elements are different on the resubmitted claim:

- PatientControlNumber (Loop 2300 – CLM01 Data Element)
- Clearinghouse Trace Number (Loop 2300 – REF02 where REF01=D9)
- Line Item ControlNumber (Loop 2400 – REF02 where REF01=6R) Duplicate paper claims should not be submitted prior to the applicable 45- day claims payment period.

Note: Claims with lab services will be denied if the CLIA number is not on the CMS-1500 form in field 23.

Coordination of Benefits

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

Claim Disputes

You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the **Blue Cross Medicare Advantage HMO** Provider Customer Service Department at **1-877-774-8592**.

Blue Cross Medicare Advantage (HMO)

Attn: Claim Disputes

PO Box 4555

Scranton, PA 18505

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Claim Information, cont'd

Process Used to Recover Overpayments on Claims

If an overpayment occurs on a **Blue Cross Medicare Advantage HMO** physician's or professional provider's claim, the process that will be used to recover an overpayment will be auto-recoupment. Should you have any questions, please contact **Blue Cross Medicare Advantage HMO** Provider Customer Service at **1-877-774-8592**.

If you would like to refund the payment for an overpaid claim, you can submit it to the **Blue Cross Medicare Advantage HMO** Claims and Refund Address:

Remittance Address:

Blue Cross and Blue Shield of Texas
Claims Overpayments
Dept. CH 14212
Palatine, IL 60055-4212

Courier Address:

Blue Cross and Blue Shield of Texas
Claims Overpayments
Box 14212
5505 North Cumberland Ave., Ste. 307
Chicago, IL 60656-1471

Note - The Electronic Refund Management tool is not available to process **Blue Cross Medicare Advantage HMO**.

Balance Billing

You **may not** bill a **Blue Cross Medicare Advantage HMO** member for a non-covered service unless:

- 1) You have informed the **Blue Cross Medicare Advantage HMO** member in advance that the service is not covered, and,
- 2) The **Blue Cross Medicare Advantage HMO** member has agreed **in writing** to pay for the services if they are not covered.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Benefits-Beneficiary Rights

Nondiscrimination

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

Additionally, a **Blue Cross Medicare Advantage HMO** plan must comply with the provisions of the Civil Rights Act, Age discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008.

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

Confidentiality

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

Basic Rule

A **Blue Cross Medicare Advantage HMO** organization offering a Medicare Advantage plan must provide the following to plan enrollees:

- all Part A and Part B, original Medicare services, if the enrollee is entitled to benefits under both parts
- Part B services if the enrollee is a grandfathered “Part B only” enrollee.

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

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Basic Rule, cont'd

Benefits-Beneficiary Rights, cont'd

- **Benefits** – **Blue Cross Medicare Advantage HMO** plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services
- **Access** – **Blue Cross Medicare Advantage HMO** enrollees must have access to all medically necessary Parts A and B services. However, **Blue Cross Medicare Advantage HMO** plans are not required to provide Medicare Advantage HMO enrollees the same access to providers that is provided under original Medicare.
- **Cost-Sharing** – **Blue Cross Medicare Advantage HMO** plans may impose cost-sharing for a particular item or service that is above or below original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under Original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries.

The following circumstances are exceptions to the rule that **Blue Cross Medicare Advantage HMO** organizations must cover the costs of original Medicare benefits:

- **Hospice** – Original Medicare (rather than the **Blue Cross Medicare Advantage HMO** organization) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan.
- **Inpatient stay during which enrollment ends** – **Blue Cross Medicare Advantage HMO** organizations must continue to cover inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of an inpatient stay
- **Clinical Trials** – Original Medicare pays for the costs of routine services provided to a **Blue Cross Medicare Advantage HMO** enrollee who joins a qualifying clinical trial. **Blue Cross Medicare Advantage HMO** plans pay the enrollee the difference between original Medicare cost-sharing incurred for qualifying clinical trial items and services and the Medicare Advantage plan's in-network cost-sharing for the same category of items and services

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

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Benefits-Beneficiary Rights, cont'd

Uniform Benefits

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

Benefits During Disasters and Catastrophic Events

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

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities
- Waive in full, requirements for gatekeeper referrals where applicable;
- Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and
- Waive the 30-day notification requirement to enrollees if all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.

Access and Availability Rules

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

- Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care.
- Establish and maintain provider network standards that define the types of providers to be used when more than one type of provider can furnish a particular item or service; identify the types of mental health and substance abuse providers in their network; and specify the types of providers who may serve as a member's PCP.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Benefits-Beneficiary Rights, cont'd

Access and Availability Rules, cont'd

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

(Examples of reasonable standards for primary care services are:

- 1) urgently needed services or emergency - immediately;
 - 2) services that are not emergency or urgently needed, but in need of medical attention - within 7 business days; and
 - 3) routine and preventive care - within 30 business days.)
- Establish, maintain, monitor and *validate credentials* for a panel of primary care providers from which the member may select a personal primary care provider
 - Provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. The **Blue Cross Medicare Advantage HMO** organization must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs.
 - Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Blue Cross Medicare Advantage HMO Member Customer Service (*phone number is listed on back of the member's ID card*) has available the following services for **Blue Cross Medicare Advantage HMO** members:

Teletypewriter services
Language services, and
Spanish speaking customer service representatives

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Benefits-Beneficiary Rights, cont'd

Access and Availability Rules, cont'd

- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management protocols that allow for individual medical necessity determinations. These standards must be available to both enrollees and providers.

Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services. Ambulance services include services dispatched through 911 or its local equivalent, when either emergency exists, or other means of transportation would endanger the beneficiary's health.

Cost-Sharing for In Network Preventive Services

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

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

Enrollees of a Medicare Advantage organization may directly access, through self-referral to any plan participating provider, for in-network screening mammography and/or influenza vaccines. The Medicare Coverage webpage is at:

www.cms.gov/medicare/coverage/determination-process/basics.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Benefits-Beneficiary Rights, cont'd

Drug Coverage

The following broad categories of drugs will be covered under the medical benefit and not covered under the original Medicare Part B, for all **Blue Cross Medicare Advantage HMO** members who have a Medicare Care Advantage Pharmacy Drug Program (MAPD plan).

Note: the following broad categories of drugs may be covered for individuals who are covered under Medicare Part B, subject to coverage requirements and regulatory and statutory limitations:

- Injectable drugs that have been determined by Medicare Contract Administrative Contractors to be "not usually self-administered" and are administered incidentally to physician services
- Durable Medical Equipment Supply Drugs. These are drugs that require administration by the use of a piece of covered DME (e.g., a nebulizer, external or implantable pump - albuterol sulfate, ipratropium bromide, some chemotherapeutic agents, etc.
- Certain vaccines including pneumococcal, hepatitis B (high or intermediate risk), influenza, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition
- Certain oral anti-cancer drugs and anti-nausea drugs.
- Hemophilia clotting factors
- Drugs used in immunosuppressive therapy (such as cyclosporine) for a beneficiary who has received a Medicare covered organ transplant
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immunodeficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of end stage renal disease
- Some drugs are covered under either Part B or Part D depending on the circumstances

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Benefits-Beneficiary Rights, cont'd

Medical Supplies Associated with the Delivery of Insulin

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

Clinical Trials

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

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

Advance Directives

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

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards – Utilization Management

Medical Necessity

Blue Cross Medicare Advantage HMO determinations must be based on:

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

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

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards – Utilization Management, cont'd

Medical Policy

Physicians and professional providers participating in the **Blue Cross Medicare Advantage HMO** network should refer directly to Medicare coverage policies when making coverage decisions. There are two types of Medicare coverage policies: National Coverage Determinations and Local Coverage Determinations. As a Medicare Advantage plan, **Blue Cross Medicare Advantage HMO** must cover all services and benefits covered by Medicare. Coverage information concerning original Medicare also applies to **Blue Cross Medicare Advantage HMO**.

National Coverage Determinations

The Centers for Medicare and Medicaid Services explains NCDs through program manuals, which are found at <https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms/>. Key manuals for coverage include:

- Medicare National Coverage Determination Manual
- Medicare Program Integrity Manual
- Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network. These articles can be found at <https://www.cms.gov/training-education/healthcare-provider-resources/mln-publications-multimedia/articles>.

Local Coverage Determinations

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

Provider may access our region's LCDs at the following website addresses:

CMS: www.cms.gov

Durable Medical Equipment: www.cgsmedicare.com

Regional Home Health Intermediary: www.palmettogba.com

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards – Utilization Management, cont'd

Medical Policy, cont'd

Medicare Coverage Database

CMS the Medicare Coverage Database which can be accessed at <https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance?redirect=/home/regsguidance.asp>.

The following areas may be searched:

- National Coverage Determinations
- National Coverage Analyses – These documents support the NCD process.

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

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

Prior Authorization Requirements List

The **Blue Cross Medicare Advantage (HMO) Prior Authorization Requirements Information** is located on the [Utilization Management](#) page on the bcbstx.com/provider website.

Inpatient Prior Authorization

The admitting health care provider, hospital or other inpatient facility should notify the **Blue Cross Medicare Advantage** Utilization Management (UM Department) if they are admitting a **Blue Cross Medicare Advantage HMO** member to a hospital or other inpatient facility.

The **Blue Cross Medicare Advantage** UM Department will review the initial hospitalization request to confirm that the hospitalization and/or procedures are Medically Necessary. If the **Blue Cross Medicare Advantage** UM Department concludes that certain services are not Medically Necessary, the **Blue Cross Medicare Advantage** physician reviewer will attempt to contact the **Blue Cross Medicare Advantage** admitting health care provider to discuss the treatment plan and treatment options prior to issuing the denial determination.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards –Utilization Management, cont'd

Availity Authorizations & Referrals

The admitting **Blue Cross Medicare Advantage HMO** health care provider or hospital/facility should utilize Availity's Authorizations & Referrals tool (HIPAA-standard 278 transaction). This tool allows for the electronic submission of inpatient admissions, select outpatient services and referral requests handled by BCBSTX. Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests.

The benefits of using this online functionality:

- No separate user enrollment needed
- Direct access within Availity portal
- Simplified 5-step process

How to access and use Availity Authorizations & Referrals:

1. Log in to [Availity](#)
2. Select Patient Registration menu option, choose Authorizations & Referrals, then Authorizations*
3. Select Payer BCBSTX, then choose your organization
4. Select a Request Type and start request
5. Review and submit your request

*Choose *Referrals* instead of Authorizations if you are submitting a referral request.

If you are not yet registered with Availity, sign up at no charge. If you need registration assistance, contact Availity Client Services at **1-800-282-4548**.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards – Utilization Management, cont'd

Concurrent Hospital Review

If an extension of the initially approved length of stay is required, the **Blue Cross Medicare Advantage HMO** admitting health care provider or **Blue Cross Medicare Advantage HMO** Hospital/Facility should contact the **Blue Cross Medicare Advantage HMO** UM Department to request the extension.

Discharge Planning

The **Blue Cross Medicare Advantage HMO** UM Department clinical staff will assist **Blue Cross Medicare Advantage HMO** participating physicians, professional providers, and facilities/hospitals in the inpatient discharge planning process. At the time of admission and during the hospitalization, the **Blue Cross Medicare Advantage HMO** UM Department clinical staff will discuss discharge planning with the **Blue Cross Medicare Advantage HMO** participating health care provider, member and member's family.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards – Case Management, cont'd

Care Coordination

The **Blue Cross Medicare Advantage HMO** organization must ensure continuity of services through arrangements that include, but are not limited to, the following:

- Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer;
- Establishing coordination of plan services that integrate services through arrangements with community and social service programs.

Utilizing procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.

- Employing systems to identify and address barriers to enrollee compliance with prescribed treatments or regimens.

To support the above requirements, **Blue Cross Medicare Advantage HMO** has a robust case management program. Our programs include care transition support, condition management, longitudinal care and complex case management programs. Case managers identify **Blue Cross Medicare Advantage HMO** members with complex needs so that timely interventions can be provided to increase positive health outcomes, lower costs, and decrease utilization. **Blue Cross Medicare Advantage HMO** Case managers, who are telephonically based, will coordinate, monitor and evaluate the options and services required to meet the **Blue Cross Medicare Advantage HMO** member's needs, by ensuring care is provided in the right place and the right time.

Initial Health Risk Assessment

CMS requires that a good faith effort is made to conduct an initial health assessment of all new **Blue Cross Medicare Advantage HMO** members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact a **Blue Cross Medicare Advantage HMO** enrollee. The original Medicare initial preventive visit (e.g., "Welcome to Medicare" preventive visit), an Annual Wellness Visit, or a recent previous physical examination in a commercial plan (to which the Medicare Advantage organization has access) would fulfill this obligation.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards – Case Management, cont'd

Annual Health Assessment

The **Blue Cross Medicare Advantage HMO** Annual Health Assessment serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings, and chronic disease monitoring. These assessments can occur in the provider's office or member's home to remove barriers to completion.

Annual Wellness Visit Resources

We have two new resources to help you care for our Medicare Advantage members during their annual wellness visits: an [Annual Wellness Visit Guide](#) and [Annual Wellness Visit form](#). These resources can help you document our members' visits to more easily meet Medicare requirements.

The guide and form are for your use only and do not need to be returned to us.

The Annual Wellness Visit Guide includes a wellness visit checklist and information on:

- Medicare coverage for wellness visits
- Correct coding for wellness visits
- Guidance to help ensure all member conditions are correctly coded each year
- Coding for other evaluation and management services, such as lab tests
- Preventive services and screenings
- Closing care gaps by performing Healthcare Effectiveness Data and Information Set (HEDIS®) measurements
- Coding tips to help minimize requests for medical records and help expedite claims processing

You may use the new Annual Wellness Visit form during wellness visits. It includes sections for members' medical history, risk factors, conditions, treatment options, coordination of care and advance care planning.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Quality Improvement Program

Performance and Compliance Standards – Quality Improvement

Quality improvement is an essential element in the delivery of care and services by **Blue Cross Medicare Advantage HMO**. To define and assist in monitoring quality improvement, **the Blue Cross Medicare Advantage HMO** Quality Improvement Program focuses on the measurement of clinical care and services delivered by participating physicians and professional providers against established goals. Key components of the program described below include the Chronic Care Improvement Program, Quality Improvement Projects and performance monitoring (HEDIS, CAPHS, HOS). Formal evaluation of the program occurs annually to assess the impact and effectiveness of the program.

Chronic Care Improvement Program

A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support-service providers, and patient self-management techniques.

Quality Improvement Project

An organization's initiative that focuses on specified clinical and non-clinical areas.

Healthcare Effectiveness Data and Information Set

A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

Consumer Assessment of Healthcare Providers and Systems

A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards –Quality Improvement, cont'd

Quality Improvement Program, cont'd

Health Outcomes Survey

This survey is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each Medicare Advantage organization health plan is surveyed. Two years later these same members are surveyed again to evaluate changes in health status.

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trends for quality of care issues. A quality of care complaint may be filed through the Medicare health plan's grievance process and/or a Quality Improvement Organization. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The QIO is comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards –Quality Improvement, cont'd

CMS Star Ratings

CMS posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five star and defines the star ratings in the following manner:

- 5 Stars Excellent performance
- 4 Stars Above average performance
- 3 Stars Average performance
- 2 Stars Below average performance
- 1 Star Poor performance

The quality scores for Medicare Advantage plans are based on performance measures that are derived from four sources:

- Healthcare Effective Data and Information Set
- Consumer Assessment of Healthcare Providers and Systems Health Outcomes Survey
- CMS administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service.

CMS groups the quality measures into five domains:

- Staying healthy: Screenings, Tests, and Vaccines
- Managing Chronic (long-term) Conditions
- Ratings of Health Plan Responsiveness and Care
- Member Complaints, Problems Getting Services, and
- Choosing to Leave the Plan
- Health Plan Customer Service

All rated plans receive both summary scores and overall scores. The summary score is used to provide quality-based payments and an overall measure of a plan's quality based on indicators specific to quality and access to care. The overall score differs from the summary score because it combines a plan's summary score with its Part D plan rating.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards –Quality Improvement, cont'd

Cooperation

Blue Cross Medicare Advantage HMO participating physicians and professional providers must comply and cooperate with all **Blue Cross Medicare Advantage HMO** Medical Management policies and procedures and in the **Blue Cross Medicare Advantage HMO** Quality Assurance and Performance Improvement Programs. In addition, **Blue Cross Medicare Advantage HMO** participating physicians and professional providers must cooperate with the independent quality review and improvement organization [Quality Improvement Organization] approved by CMS in its review of quality of care and investigation of quality complaints on behalf of the Medicare program. Texas Medical Foundation is the QIO for **Blue Cross Medicare Advantage HMO**.

Utilization Management Program

The Utilization Management program does not prohibit **Blue Cross Medicare Advantage HMO** physicians and professional providers from advocating on behalf of members within the utilization management process.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards –Quality Improvement, cont'd

Specialty Care Health Care Providers

A **Blue Cross Medicare Advantage HMO** member may not self- refer to any **Blue Cross Medicare Advantage HMO** participating specialty care health care provider. If it is necessary to utilize a non-participating specialty care health care provider due to network inadequacy or continuity of care concerns, the health care provider must obtain prior authorization from the UM Department for claims to pay at the in-network benefit level. If prior authorization is not obtained, claims will be denied.

Members self-referring and participating health care providers coordinating care access to participating specialty care health care providers can check the **Blue Cross Medicare Advantage HMO** Provider Directory to identify the specialty care health care providers that are participating in the **Blue Cross Medicare Advantage HMO** network.

The referring health care provider should provide the specialty care health care provider with the following clinical information:

- Member's name
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the specialty care health care provider

Specialty Care Health Care Providers Responsibilities

Following an evaluation of a **Blue Cross Medicare Advantage HMO Member**, the Specialty Care Health Care Provider should:

- Contact the referring health care provider to discuss the **Blue Cross Medicare Advantage HMO** Member's condition and any recommendation for treatment or follow up care, and
- Send the referring **Blue Cross Medicare Advantage HMO** health care provider the consultation report including medical findings, test results, assessment, recommendations, treatment plan and any other pertinent information.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance and Compliance Standards –Quality Improvement, cont'd

30 Day Readmissions

Inpatient readmission rate is a quality of care metric that incentivizes facilities to improve quality of care to ensure member safety and promote the health of the member. Consistent with CMS payment methodology and to help improve quality for our members, BCBSTX will review readmissions to an acute care facility that occur within 30 days of discharge from the same facility. For participating providers, BCBSTX performs a clinical validation of acute care facility claims to determine if such readmissions to the same facility within 30 days of discharge are related and may deny payment to the facility for related readmissions.

Upon request, the facility must forward any medical records and related documents involving the admissions. These documents will be clinically reviewed to determine if readmissions within 30-days were clinically related. If it is determined that the stays were clinically related, BCBSTX will not pay for the second diagnosis-related group.

Exclusions: Readmissions, including but not limited to, under the following circumstances are excluded from 30-day readmission review:

- Obstetrical readmissions
- Transfers of patients to receive care that was unable to be provided at the initial facility
- Skilled Nursing Facility and rehabilitation facility admissions
- Planned readmissions for repetitive health care treatments, including but not limited to: chemotherapy, staged surgical procedures, procedures involving malignancies, burns procedures, cystic fibrosis procedures, and other treatments
- Patient non-compliance, ONLY if this is adequately documented in medical records

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Care Management

Care Management

Blue Cross Medicare Advantage HMO will assist in managing the care of members with acute or chronic conditions that can benefit from care coordination and assistance. **Blue Cross Medicare Advantage HMO** participating physicians and professional providers shall assist and cooperate with the **Blue Cross Medicare Advantage HMO** Care Management Programs. Under its Care Management Program, and in coordination with **Blue Cross Medicare Advantage HMO** participating physicians and professional providers, **Blue Cross Medicare Advantage HMO** shall:

- Implement procedures to ensure that **Blue Cross Medicare Advantage HMO** members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.
- Make best efforts to conduct a health assessment of all new Blue Cross Medicare Advantage HMO members within 90 days of the effective date of enrollment;
- Identify **Blue Cross Medicare Advantage HMO** individuals with complex or serious medical conditions;
- Establish and implement care management plans that:
 - Are appropriate;
 - Facilitate direct access visits to specialty care physicians or professional providers;
 - Are time specific and updated periodically;
 - Facilitate coordination among **Blue Cross Medicare Advantage HMO** physicians and professional providers; and
 - Consider the **Blue Cross Medicare Advantage HMO** member's input.

The **Blue Cross Medicare Advantage HMO** participating health care provider will diagnose, assess, treat and monitor those conditions on an ongoing basis.

The Care Management Program includes, but is not limited to:

- Identification and monitoring of quality and performance indicators;
- Implementation of measures that contribute to improving quality of care and cost-effective management of targeted conditions;
- Promotion of preventive care strategies to keep **Blue Cross Medicare Advantage HMO** members healthy;
- Promotion of **Blue Cross Medicare Advantage HMO** member education and behavioral modification that improve outcomes; and
- Evaluation of outcomes and program effectiveness.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Care Management, cont'd

Care Management, cont'd

- Promotion of **Blue Cross Medicare Advantage HMO** member education and behavioral modification that improve outcomes; and
- Evaluation of outcomes and program effectiveness.

Blue Cross Medicare Advantage HMO Members are informed of available programs through the enrollment process, marketing materials, and discussions with **Blue Cross Medicare Advantage HMO** participating physicians and professional providers. **Blue Cross Medicare Advantage HMO** will proactively identify **Blue Cross Medicare Advantage HMO** members who could benefit from Care Management and encourage enrollment in the Care Management Program including the Disease Management Programs for certain chronic care conditions.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Care Management, cont'd

Second Medical or Surgical Opinion

A **Blue Cross Medicare Advantage HMO** member may request a second opinion if:

- the **Blue Cross Medicare Advantage HMO** member disputes the reasonableness of the treatment recommendation;
- the **Blue Cross Medicare Advantage HMO** member disputes necessity of the recommended procedure; or
- the **Blue Cross Medicare Advantage HMO** member does not respond to medical treatment after a reasonable amount of time.

Clinical Review Criteria

The **Blue Cross Medicare Advantage HMO** Clinical Quality Improvement Committee will review and approve the utilization management processes and clinical review criteria used to determine whether services are Medically Necessary. **Blue Cross Medicare Advantage HMO** currently uses Milliman Care Guidelines[®] which promotes consistent decisions based on nationally accepted, physician-created clinical criteria for Inpatient Certification and concurrent review requests. For more information or to receive a copy of these guidelines, please contact the **Blue Cross Medicare Advantage HMO** Utilization Management (UM) Department at **1-877-774-8592**.

Blue Cross Medicare Advantage HMO may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to **Blue Cross Medicare Advantage HMO** participating physicians and professional providers through the monthly Blue Review newsletter. Clinical Practice Guidelines are published in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlueHealth** Provider Manual and is also located [online](#), under the Standards and Requirements area, then click on Manuals.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Care Management, cont'd

Health Risk Assessment

A health risk assessment questionnaire will be sent to **Blue Cross Medicare Advantage HMO** members as a component of the enrollment materials. **Blue Cross Medicare Advantage HMO** Medical Care Management staff will evaluate results and:

- Identify health care needs;
- Assist with access to health care services;
- Assist with coordination of care;
- Provide telephonic educational or written materials via mail as needed; and
- Refer **Blue Cross Medicare Advantage HMO** members to appropriate case and disease management programs as needed.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Care Management, cont'd

Disease Management Programs

The Disease Management Programs include:

Medical:

- Diabetes
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure

Behavioral Health:

- Depression
- Substance Abuse
- Schizophrenia/Psychotic disorders
- Bipolar
- Anxiety/Panic disorders
- Alzheimer/Dementia

Blue Cross Medicare Advantage member participation is voluntary. **Blue Cross Medicare Advantage HMO** members receive both telephonic and hard copy educational information to enhance self- management of their condition. The treatment by a **Blue Cross Medicare Advantage HMO** health care provider is an integral part of the disease management program.

For additional information on **Blue Cross Medicare Advantage HMO** Disease/Care Management Programs, call the **Blue Cross Medicare Advantage HMO** Disease/Care Management Programs phone number listed on the **Blue Cross Medicare Advantage Provider Quick Reference Guide** which can be located on the [Blue Cross Medicare Advantage \(HMO\) page](#).

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance Standards and Compliance Obligations

Evaluating Performance of Participating Health Care Providers

When evaluating the performance of a **Blue Cross Medicare Advantage HMO** participating health care provider, **Blue Cross Medicare Advantage HMO** will review at a minimum the following areas:

- **Quality of Care** - measured by clinical data related to the appropriateness of a **Blue Cross Medicare Advantage HMO** member's care and member outcomes.
- **Efficiency of Care** - measured by clinical and financial data related to a **Blue Cross Medicare Advantage HMO** member's health care costs.
- **Member Satisfaction** - measured by the **Blue Cross Medicare Advantage HMO** members' reports regarding accessibility, quality of health care, member, participating health care provider relations, and the comfort of the practice setting.
- **Administrative Requirements** - measured by the **Blue Cross Medicare Advantage HMO** participating physician's or professional provider's methods and systems for keeping records and transmitting information, hours of operation, appointment waiting time, and appointment availability.
- **Participation in Clinical Standards** - measured by the **Blue Cross Medicare Advantage HMO** participating health care provider's involvement with panels used to monitor quality of care standards.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance Standards and Compliance Obligations, cont'd

Health Care Provider Compliance to Standards of Care

Blue Cross Medicare Advantage HMO participating health care providers must comply with all applicable laws and licensing requirements. In addition, **Blue Cross Medicare Advantage HMO** participating health care providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. **Blue Cross Medicare Advantage HMO** participating health care providers must also comply with the **Blue Cross Medicare Advantage HMO** standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity); and
- All federal, state and local laws regarding the conduct of their profession.

Blue Cross Medicare Advantage HMO participating health care providers must also comply with **Blue Cross Medicare Advantage HMO** policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care;
- Prior authorization requirements and time frames;
- **Blue Cross Medicare Advantage HMO** participating health care provider credentialing requirements;
- **Blue Cross Medicare Advantage HMO** Care Management and Disease Management Program care coordination referrals;
- Appropriate release of inpatient and outpatient utilization and outcomes information;
- Accessibility of **Blue Cross Medicare Advantage HMO** member medical record information to fulfill the business and clinical needs of **Blue Cross Medicare Advantage HMO**;
- Providing treatment to **Blue Cross Medicare Advantage HMO** members at the appropriate level of care; and
- Providing equal access and treatment to all **Blue Cross Medicare Advantage HMO** members.

Blue Cross Medicare Advantage (HMO) Provider Manual -Supplement

Performance Standards and Compliance Obligations, cont'd

Health Care Provider Compliance to Standards of Care, cont'd

Blue Cross Medicare Advantage HMO participating health care providers acting within the lawful scope of practice are encouraged to advise patients who are members of **Blue Cross Medicare Advantage HMO** about:

1. The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options;
2. The risks, benefits, and consequences of treatment or non-treatment; and
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Such actions shall not be considered non-supportive of **Blue Cross Medicare Advantage HMO**.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Performance Standards and Compliance Obligations, cont'd

Laws Regarding Federal Funds

Payments that participating health care providers receive for furnishing services to **Blue Cross Medicare Advantage HMO** members are, in whole or part, from Federal funds. Therefore, participating health care providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

Marketing

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

Sanctions under Federal Health Programs and State Law

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

Participating health care providers must disclose to **Blue Cross Medicare Advantage HMO** whether the participating health care providers or any staff member or subcontractor has been the subject of any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of Texas; the federal government; or any public insurer.

Participating health care providers must notify **Blue Cross Medicare Advantage HMO** immediately if any such sanction is imposed on a participating health care provider, a staff member or a subcontractor.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Selection and Retention of Participating Physicians and Professional Providers

Participation Requirements

To participate in **Blue Cross Medicare Advantage HMO**, the health care provider:

- 1) must have privileges at one of the **Blue Cross Medicare Advantage HMO** participating hospitals (*unless inpatient admissions are uncommon or not required by Blue Cross Medicare Advantage HMO for the physician's or professional provider's specialty*)
- 2) must have a valid National Provider Identifier Number
- 3) must sign a **Blue Cross Medicare Advantage HMO** agreement/ amendment, and
- 4) cannot have opted-out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations. Medicare Advantage HMO participating health care providers cannot be named on the Office of the Inspector General or Government Services Administration lists which identify health care providers found guilty of fraudulent billing, misrepresentation of credentials, etc. **Blue Cross Medicare Advantage HMO** participating health care providers cannot be sanctioned by the Office of Personnel Management or be prohibited from participation in the Federal Employees Health Benefit Program.

Credentialing & Recredentialing of Participating Health Care Providers

Blue Cross Medicare Advantage HMO continuously reviews and evaluates participating physicians and professional providers information, and recredentials participating physicians and professional providers every three years. The credentialing guidelines are subject to change based on industry requirements and **Blue Cross Medicare Advantage HMO** standards.

Credentialing & Recredentialing of Participating Institution Providers

Blue Cross Medicare Advantage HMO continuously reviews and evaluates Institution Provider information and recertifies Institution Providers every three years. The credentialing guidelines are subject to change based on industry requirements and **Blue Cross Medicare Advantage HMO** standards.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Selection and Retention of Participating Physicians and Professional Providers, cont'd

Appeal Process for Health Care Provider Participation Decisions

If **Blue Cross Medicare Advantage HMO** decides to suspend, terminate or non-renew a health care provider's participation status, **Blue Cross Medicare Advantage HMO** will give the affected health care provider written notice of the reasons for the action including, if relevant, the standards and profiling data used to evaluate the health care provider and the numbers and mix of health care providers needed by **Blue Cross Medicare Advantage HMO**. **Blue Cross Medicare Advantage HMO** will allow the health care provider to appeal the action to a hearing panel and give the health care provider written notice of his/her right to an appeal hearing and the process and timing for requesting a hearing. **Blue Cross Medicare Advantage HMO** will ensure that the majority of the hearing panel members are peers of the affected health care provider. A recommendation by the hearing panel is advisory and is not binding on **Blue Cross Medicare Advantage HMO**.

If a reduction, suspension or termination of a health care provider's participation is final and is the result of quality of care deficiencies, **Blue Cross Medicare Advantage HMO** will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted health care provider groups must ensure that these procedures apply equally to health care providers within those subcontracted groups.

Notification to Members of Health Care Provider Termination

Blue Cross Medicare Advantage HMO will make a good faith effort to provide written notice of termination of a participating health care provider to all members who are patients seen on a regular basis by that health care provider at least 30 calendar days before the termination effective date regardless of the reason for the termination.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Medical Records

Medical Record Review

A **Blue Cross Medicare Advantage HMO** representative may visit the participating health care provider's office to review the medical records of **Blue Cross Medicare Advantage HMO** members as described in the Physician Office Review Program section of the ***Blue Essentials and Blue Advantage HMO Health Care Provider Manual***.

Standards for Medical Records

Blue Cross Medicare Advantage HMO participating health care providers must have a system in place for maintaining medical records that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the member's medical record. Each medical record chart must include all of the elements specified in the **Blue Essentials and Blue Advantage HMO** Health Care Provider Manual. In addition, each medical record must also include the following:

- All health care providers participating in the member's care and information on services furnished by these health care providers;
 - Prescribed medications, including dosages and dates of initial or refill prescriptions;
 - Advance Directives - the health care provider must document whether or not the member has executed an Advance Directive;
 - Physical examinations, necessary treatments, possible risk factors for particular treatments; and
 - Evidence of Member input into the proposed treatment plan.
-

Advance Directive

Blue Cross Medicare Advantage HMO participating health care providers must document in a prominent part of the member's current medical record whether or not the member has executed an Advance Directive.

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

Confidentiality of Member Information

Blue Cross Medicare Advantage HMO participating health care providers must comply with all state and Federal laws concerning confidentiality of health and other information about members. **Blue Cross Medicare Advantage HMO** participating health care providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Reporting Obligations

Cooperation in Meeting CMS Requirements

Blue Cross Medicare Advantage HMO must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program, and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates, information on member satisfaction, and information on health outcomes.

Blue Cross Medicare Advantage HMO participating physicians and professional providers must cooperate with **Blue Cross Medicare Advantage HMO** in its data reporting obligations by providing to **Blue Cross Medicare Advantage HMO** any information that it needs to meet its obligations.

Certification of Diagnostic Data

Blue Cross Medicare Advantage HMO is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a physician or professional provider, supplier, or other practitioner (encounter data). Participating physicians and professional providers that furnish diagnostic data to assist **Blue Cross Medicare Advantage HMO** in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances

Initial Decisions

The “initial decision” is the first decision **Blue Cross Medicare Advantage HMO** makes regarding coverage or payment for care. In some instances, a **Blue Cross Medicare Advantage HMO** participating health care provider, acting on behalf of the member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a **Blue Cross Medicare Advantage HMO** member asks **Blue Cross Medicare Advantage HMO** to pay for medical care the member has already received, this is a request for an “initial decision” about payment for care.
- If a **Blue Cross Medicare Advantage HMO** member, or participating health care provider acting on behalf of a **Blue Cross Medicare Advantage HMO** member, asks for prior authorization for treatment, this is a request for an “initial decision” about whether the treatment is covered by **Blue Cross Medicare Advantage HMO**.
- If a **Blue Cross Medicare Advantage HMO** member asks for a specific type of medical treatment from a participating **Blue Cross Medicare Advantage HMO** health care provider, this is a request for an “initial decision” about whether the treatment the member wants is covered by **Blue Cross Medicare Advantage HMO**.

Blue Cross Medicare Advantage HMO will generally make decisions regarding payment for care that members have already received within 30 calendar days.

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

A **Blue Cross Medicare Advantage HMO** member can ask for an expedited decision **only** if the **Blue Cross Medicare Advantage HMO** member or any **Blue Cross Medicare Advantage HMO** health care provider believes that waiting for a standard decision could jeopardize the life or health of the **Blue Cross Medicare Advantage HMO** member or the **Blue Cross Medicare Advantage HMO** member’s ability to regain maximum function. If an expedited decision is requested by the **Blue Cross Medicare Advantage HMO** member or health care provider, **Blue Cross Medicare Advantage HMO** will automatically provide an expedited decision.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances, cont'd

Initial Decisions, cont'd

If **Blue Cross Medicare Advantage HMO** does not make a decision within the required timeframe and does not notify the **Blue Cross Medicare Advantage HMO** member regarding why the timeframe must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth below.



Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances, cont'd

Appeals and Grievances

Blue Cross Medicare Advantage HMO members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints. All **Blue Cross Medicare Advantage HMO** participating physicians and professional providers must cooperate in the **Blue Cross Medicare Advantage HMO** Appeals and Grievances process.

- An “appeal” is a complaint a member makes when the **Blue Cross Medicare Advantage HMO** member wants **Blue Cross Medicare Advantage HMO** to reconsider and change an initial decision (by Medicare Advantage HMO or a **Blue Cross Medicare Advantage HMO** participating health care provider) about what services are necessary or covered or what **Blue Cross Medicare Advantage HMO** will pay for a service.
- A “grievance” is a complaint a **Blue Cross Medicare Advantage HMO** member makes regarding any other type of problem with **Blue Cross Medicare Advantage HMO** or a **Blue Cross Medicare Advantage HMO** participating health care provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating health care providers’ facilities are grievances.

Utilization Management Appeals Address and Phone & Fax Numbers

Appeals regarding outpatient or inpatient prior authorization for, or termination of coverage of, a health care service should be sent to:

Blue Cross Medicare Advantage HMO

Attn: Appeals Department

PO Box 663099

Dallas, TX 75266

Fax to: 800-419-2009

For an Expedited Appeal Only, call 1-877-774-8592 For Claim
Inquiries, contact:

Blue Cross Medicare Advantage HMO

Provider Customer Service

1-877-774-8592

Resolving Grievances and Complaints

If a **Blue Cross Medicare Advantage HMO** member has a Grievance about **Blue Cross Medicare Advantage HMO**, a health care provider or any other issue, participating health care providers should instruct the member to contact the **Blue Cross Medicare Advantage HMO** Member Customer Service Department at the number listed on the back of the **Blue Cross Medicare Advantage HMO** member’s ID card.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances, cont'd

Resolving Appeals

A **Blue Cross Medicare Advantage HMO** member may appeal an adverse initial decision by **Blue Cross Medicare Advantage HMO** or a participating **Blue Cross Medicare Advantage HMO** health care provider concerning a prior authorization for or termination of coverage of, a health care service. A **Blue Cross Medicare Advantage HMO** member may also appeal an adverse initial decision by **Blue Cross Medicare Advantage HMO** concerning payment for a health care service. A **Blue Cross Medicare Advantage HMO** member's appeal of an initial decision about authorizing health care or terminating coverage of a service must generally be resolved by **Blue Cross Medicare Advantage HMO** within 30 calendar days, or sooner if the **Blue Cross Medicare Advantage HMO** member's health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

If the normal time period for an appeal could jeopardize the life or health of the **Blue Cross Medicare Advantage HMO** member or the member's ability to regain maximum function, the member or the **Blue Cross Medicare Advantage HMO** member's health care provider can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the **Blue Cross Medicare Advantage HMO** member's interest to extend this time period. When a **Blue Cross Medicare Advantage HMO** member or health care provider requests an expedited appeal, **Blue Cross Medicare Advantage HMO** will automatically expedite the appeal.

A special type of appeal applies only to Hospital discharges. If the **Blue Cross Medicare Advantage HMO** member thinks **Blue Cross Medicare Advantage HMO** coverage of a hospital stay is ending too soon, the **Blue Cross Medicare Advantage HMO** member can appeal directly and immediately to the Quality Improvement Organization (QIO). However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that **Blue Cross Medicare Advantage HMO** coverage of the stay is ending. If the **Blue Cross Medicare Advantage HMO** member misses this deadline, the member can request an expedited appeal from **Blue Cross Medicare Advantage HMO**.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances, cont'd

Resolving Appeals, cont'd

Another special type of appeal applies only to a **Blue Cross Medicare Advantage HMO** member dispute regarding when coverage will end for skilled nursing facility, Home Health Agency or comprehensive outpatient rehabilitation facility services. SNFs, HHAs and CORFs are responsible for providing **Blue Cross Medicare Advantage HMO** members with a written notice at least two days before their services are scheduled to end. If the **Blue Cross Medicare Advantage HMO** member thinks their coverage is ending too soon, the **Blue Cross Medicare Advantage HMO** member can appeal directly and immediately to the QIO.

If the **Blue Cross Medicare Advantage HMO** member gets the notice 2 days **before** coverage ends, the **Blue Cross Medicare Advantage HMO** member must request an appeal to the QIO no later than noon of the first day after the day the **Blue Cross Medicare Advantage HMO** member gets the notice.

If the **Blue Cross Medicare Advantage HMO** member gets the notice **more than 2 days** before coverage ends, then the **Blue Cross Medicare Advantage HMO** member must make the request no later than noon the day **before** the date that coverage ends.

If the **Blue Cross Medicare Advantage HMO** member misses the deadline for appealing to the QIO, the **Blue Cross Medicare Advantage HMO** member can request an expedited appeal from **Blue Cross Medicare Advantage HMO**.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances, cont'd

Further Appeal Rights

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

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the **Blue Cross Medicare Advantage HMO** member may appeal to an Administrative Law Judge. If the **Blue Cross Medicare Advantage HMO** member is not satisfied with the ALJ's decision, the **Blue Cross Medicare Advantage HMO** member may request review by the Medicare Appeals Council. If the MAC refuses to hear the case or issues an adverse decision, the **Blue Cross Medicare Advantage HMO** member may be able to request Federal Judicial Review.

Participating Health Care Provider Obligations – Organization Determinations

At each patient encounter with a **Blue Cross Medicare Advantage HMO** member, the participating health care provider must notify the **Blue Cross Medicare Advantage HMO** member of his or her right to receive, upon request, a detailed written notice from **Blue Cross Medicare Advantage HMO** regarding the **Blue Cross Medicare Advantage HMO** member's services. The participating health care provider's notification must provide the **Blue Cross Medicare Advantage HMO** member with the information necessary to contact **Blue Cross Medicare Advantage HMO** and must comply with any other requirements specified by Centers for Medicare & Medicaid Services (CMS). If a **Blue Cross Medicare Advantage HMO** member requests Medicare Advantage HMO to provide a detailed notice of a participating health care provider's decision to deny a service in whole or part, **Blue Cross Medicare Advantage HMO** must give the member a written notice of the determination.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Initial Decisions, Appeals and Grievances, cont'd

Participating Health Care Provider Obligations – Appeals

Blue Cross Medicare Advantage HMO participating health care providers must also cooperate with **Blue Cross Medicare Advantage HMO** and members in providing necessary information to resolve the appeals within the required time frames. **Blue Cross Medicare Advantage HMO** participating health care providers must provide the pertinent medical records and any other relevant information. In some instances, **Blue Cross Medicare Advantage HMO** participating health care providers must provide the records and information quickly to allow **Blue Cross Medicare Advantage HMO**, the IRE or QIO to make an expedited decision.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Members' Rights and Responsibilities

Rights

Blue Cross Medicare Advantage HMO members have the right to timely, high quality care, and treatment with dignity and respect. **Blue Cross Medicare Advantage HMO** participating physicians and professional providers must respect the rights of all **Blue Cross Medicare Advantage HMO** members.

Blue Cross Medicare Advantage HMO members have been informed that they have the following rights:

- Choice of a qualified participating health care provider and contracting hospital;
- Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage;
- Timely access to their participating health care provider and recommendations to specialty care health care providers when Medically Necessary;
- To receive Emergency Services when the member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists;
- To actively participate in decisions regarding their health and treatment options;
- To receive Urgently Needed Services when traveling outside of the **Blue Cross Medicare Advantage HMO** Service Area or in the **Blue Cross Medicare Advantage HMO** Service Area when unusual or extenuating circumstances prevent the member from obtaining care from a participating health care provider;
- To request the aggregate number of grievances and appeals and dispositions;
- To request information regarding health care provider compensation;
- To request information regarding the financial condition of **Blue Cross Medicare Advantage HMO**;

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Members' Rights and Responsibilities, cont'd

Rights, cont'd

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

Blue Cross Medicare Advantage (HMO) Provider Manual -Supplement

Members' Rights and Responsibilities, cont'd

Responsibilities

Blue Cross Medicare Advantage HMO members have been informed that they have the following responsibilities:

- To get familiar with their coverage and the rules they must follow to get care as a member;
- To give their **Blue Cross Medicare Advantage HMO** physician or professional provider and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their **Blue Cross Medicare Advantage HMO** physicians and professional providers agree upon. To be sure to ask their **Blue Cross Medicare Advantage HMO** physician or professional provider and other providers if they have any questions;
- To act in a way that supports the care given to other patients and to help the smooth running of their physician's or professional provider's office, hospitals, and other offices;
- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities; and
- To let **Blue Cross Medicare Advantage HMO** know if they have any questions, concerns, problems, or suggestions.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Members' Rights and Responsibilities, cont'd

Member Satisfaction

Blue Cross Medicare Advantage HMO periodically surveys **Blue Cross Medicare Advantage HMO** members to measure overall customer satisfaction as well as satisfaction with the care received from **Blue Cross Medicare Advantage HMO** participating physicians and professional providers. Survey information is reviewed by **Blue Cross Medicare Advantage HMO** and results are shared with the **Blue Cross Medicare Advantage HMO** participating physicians and professional providers.

Services Provided in a Culturally Competent Manner

Blue Cross Medicare Advantage HMO is obligated to ensure that services are provided in a culturally competent manner to all **Blue Cross Medicare Advantage HMO** members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. **Blue Cross Medicare Advantage HMO** participating physicians and professional providers must cooperate with **Blue Cross Medicare Advantage HMO** in meeting this obligation.

Blue Cross Medicare Advantage HMO Member Customer Service (*phone number is listed on the back of the Member's ID card*) has available the following services for **Blue Cross Medicare Advantage HMO** members:

- Teletypewriter services
 - Language services, and
 - Spanish speaking customer service representatives
-

Advance Directive

Blue Cross Medicare Advantage HMO members have the right to complete an "Advance Directive" statement. This statement indicates, in advance, the **Blue Cross Medicare Advantage HMO** member's choices for treatment to be followed in the event the **Blue Cross Medicare Advantage HMO** member becomes incapacitated or otherwise unable to make medical treatment decisions. **Blue Cross Medicare Advantage HMO** suggests that **Blue Cross Medicare Advantage HMO** participating physicians and professional providers have Advance Directive forms in their office and available to members.

Member Complaints and Grievances

Blue Cross Medicare Advantage HMO tracks all complaints and grievances to identify areas of improvement for **Blue Cross Medicare Advantage HMO**. This information is reviewed by the Quality Improvement Committee.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Obligation to Provide Access to Care

**Member
Access To
Health Care
Guidelines**

The following appointment availability access guidelines should be used to ensure timely access to medical care and behavioral health care:

Provider Type	Appointment:	Access/Availability Standard:
Medical, Mental Health, Substance Abuse	Initial new patient visit	within 30 business days
Medical	Annual Physical Exam	within 30 business days.
Medical	Preventive care	within 30 business days
Medical, Mental Health, Substance Abuse	Symptomatic non-urgent care	within 5 business days
Medical	Services that are not emergency or urgently needed, but the enrollee requires medical attention	within 7 business days
Medical, Mental Health, Substance Abuse	Urgent care visit	within 24 hours
Medical, Mental Health, Substance Abuse	Emergency Care/After-hours access	immediately or directed to emergency room
Medical, Mental Health, Substance Abuse	In-office wait time	within 30 minutes

Adherence to **Blue Cross Medicare Advantage HMO** member access guidelines will be monitored through the office site visits and the tracking of complaints/grievances related to access and availability which are reviewed by the Clinical Quality Improvement Committee.

All participating **Blue Cross Medicare Advantage HMO** health care providers and hospitals/facilities will treat all **Blue Cross Medicare Advantage HMO** members with equal dignity and consideration as their non-**Blue Cross Medicare Advantage HMO** patients.

**Health Care
Provider
Availability**

Blue Cross Medicare Advantage HMO participating health care providers shall provide coverage 24 hours a day, 7 days a week. When a **Blue Cross Medicare Advantage HMO** participating health care provider is unavailable to provide services, he or she must ensure that another **Blue Cross Medicare Advantage HMO** participating health care provider is available. Hours of operation must not discriminate against **Blue Cross Medicare Advantage HMO** members relative to other members.

Blue Cross Medicare Advantage (HMO) Provider Manual -Supplement

Obligation to Provide Access to Care, cont'd

Health Care Provider Availability, cont.

The **Blue Cross Medicare Advantage HMO** member should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g., emergency cases) and be provided with an alternative appointment.

After-hours access shall be provided to assure a response to after hour phone calls. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek emergency services.

Health Care Provider Office Confidentiality Statement

Blue Cross Medicare Advantage HMO members have the right to privacy and confidentiality regarding their health care records and information. **Blue Cross Medicare Advantage HMO** participating health care providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Prohibition Against Discrimination

Neither **Blue Cross Medicare Advantage HMO** or **Blue Cross Medicare Advantage HMO** participating health care providers may deny, limit, or condition the coverage or furnishing of services to Members on the basis of any factor that is related to health status, including, but not limited to the following:

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

Blue Cross Medicare Advantage HMO participating health care providers must have practice policies demonstrating that they accept for treatment any **Blue Cross Medicare Advantage HMO** member in need of health care services they provide.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Glossary of Terms

(For use in this Blue Cross Medicare Advantage HMO Provider Manual Supplement)

Appeal	Any of the procedures that deal with the review of adverse organization determinations on the health care services a Blue Cross Medicare Advantage HMO member is entitled to receive or any amounts that the Blue Cross Medicare Advantage HMO member must pay for a covered service. These procedures include reconsiderations by Blue Cross Medicare Advantage HMO , an independent review entity, hearings before Administrative Law Judge, review by the Medicare Appeals Council and Federal Judicial Review.
Basic Benefits	All health care services that are covered under the Medicare Part A and Part B programs except Hospice services and additional benefits. All Members of Blue Cross Medicare Advantage HMO receive all Basic CMS Benefits.
Centers for Medicare & Medicaid Services	The Centers for Medicare & Medicaid Services, the Federal Agency responsible for administering Medicare.
Covered Services	Those benefits, services or supplies which are: <ul style="list-style-type: none">• Provided or furnished at the in-network benefit level by participating Blue Cross Medicare Advantage HMO physicians and professional providers or authorized by Blue Cross Medicare Advantage HMO or its participating physicians and professional providers.• Provided or furnished by non-participating physicians and professional providers at the in-network benefit level when authorized by Blue Cross Medicare Advantage HMO due to network inadequacy or continuity of care concerns.• Provided or furnished by non-participating physicians and professional providers at the out-of-network benefit level.• Emergency Services that are provided or furnished at the in-network benefit level, and may be provided by non-participating physicians and professional providers.• Renal dialysis services provided at the in-network benefit level while the member is temporarily outside the Service Area.• Basic and Supplemental Benefits.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Glossary of Terms, cont'd

(For use in this Blue Cross Medicare Advantage HMO Provider Manual Supplement)

**Emergency
Medical
Condition**

Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

**Experimental
Procedures
and Items**

Items and procedures determined by **Blue Cross Medicare Advantage HMO** and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, **Blue Cross Medicare Advantage HMO** will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Grievance

Any **complaint** or **dispute** other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are: waiting times in health care provider offices; and rudeness or unresponsiveness of Customer Service Staff.

**Home Health
Agency**

A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in the member's home when Medically Necessary, when members are confined to their home and when authorized by their participating health care provider.

Hospice

An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in the state of Texas, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Glossary of Terms, cont'd

(For use in this Blue Cross Medicare Advantage HMO Provider Manual Supplement)

Medically Necessary Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of a Member or a member's health care provider.

Medicare The Federal Government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

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

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

Member The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in the **Blue Cross Medicare Advantage HMO** and whose enrollment has been confirmed by CMS.

Non-Contracting Medical Health Care Provider or Facility Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract with **Blue Cross Medicare Advantage HMO** to deliver Covered Services to **Blue Cross Medicare Advantage HMO** members.

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

Glossary of Terms, cont'd

(For use in this Blue Cross Medicare Advantage HMO Provider Manual Supplement)

**Participating
Health Care
Provider**

The **Blue Cross Medicare Advantage HMO** participating health care provider who a member chooses to coordinate their health care is responsible for providing covered services for **Blue Cross Medicare Advantage HMO** members and coordinating specialty care.

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

**Quality
Improvement
Organization**

The independent quality review and improvement organization approved by CMS. Texas Medical Foundation is the QIO for **Blue Cross Medicare Advantage HMO**.

**Service
Area**

A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. Refer to [page 8](#) above for the approved Texas Service area.

Provider Quick Reference Guide

**Key
Contacts
List**

Refer to the **Provider Quick Reference Guide** on the [Blue Cross Medicare Advantage \(HMO\) page](#).

Blue Cross Medicare Advantage (HMO) Provider Manual - Supplement

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