Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Medicare Advantage HMO and PPO Plans

Blue Advantage Provider Administrative Manual

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INTRODUCTION

Welcome to Blue Advantage

Thank you for participating in Blue Advantage. As a participating provider, you play an important role in the delivery of healthcare services to Blue Advantage Plan members, and you have our commitment to work collaboratively with you to provide members access to excellent care and coverage.

This Blue Advantage Provider Administrative Manual is intended to be used as a guide to assist providers in delivering covered services to Blue Advantage members. This manual contains policies, procedures and general reference information, including minimum standards of care, which are required of Blue Advantage providers and govern the administration of the Medicare Advantage and Prescription Drug (MA-PD) plans. The information in this manual offers general guidelines that are applicable to both Blue Advantage (HMO) and Blue Advantage (PPO) benefit plans except where noted. This manual also contains a brief summary of the Blue Advantage plans and an overview of the MA-PD. When this manual says "we," "us" or "our," it means Blue Cross and Blue Shield of Louisiana or its subsidiary, HMO Louisiana, Inc. When it says "plan" or "our plan," it means both Blue Advantage plans. Information contained in this manual that applies to only Blue Advantage (HMO) or Blue Advantage (PPO), will be noted accordingly.

This information is provided to promote an effective understanding of Blue Advantage operations and supplements the provider participation contract. This manual is available on the **Blue Advantage Provider Portal**, which is accessible through iLinkBlue (www.BCBSLA.com/ilinkblue) by clicking on the "Blue Advantage" menu option under "Other Sites." The contact information is in the Plan Information Contact List located in the front of this manual.

Blue Advantage may revise this manual to reflect changes in policies and procedures as necessary to meet compliance. Upon occurrence, network providers will be notified of revision(s) including the effective date.

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Plan Information Contact List

Service	Contact Information
Blue Advantage Customer Service	For inquiries that cannot be addressed through the Blue Advantage Provider Portal, you may contact Blue Advantage Customer Support at: phone: 1-866-508-7145 fax: 1-877-528-5820 email: customerservice@blueadvantage.bcbsla.com mail: Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc. P.O. Box 7003 Troy, MI 48007
Blue Advantage Provider Portal	For assistance with routine inquiries such as claim status checks, member eligibility, benefit verification or confirmation of prior authorization, use the Blue Advantage Provider Portal, located within iLinkBlue (www.BCBSLA.com/ilinkblue). Click on "Blue Advantage" under "Other Sites." For technical questions relating to registration or login access to the Blue Advantage Provider Portal: phone: 1-866-397-2812
Blue Advantage Provider Directory	For a list of providers in our Blue Advantage network, use the Provider Directory, located on the Blue Advantage Provider Portal, within iLinkBlue www.BCBSLA.com/ilinkblue. Click on "Blue Advantage" under "Other Sites," then "Find a Provider."

Service	Contact Information
Authorizations (including Part B Drugs, Case and Medical Management)	Inpatient Programs: To request a prior authorization for inpatient services, please submit authorization requests to the Blue Advantage Authorizations department at: fax: 1-877-528-5818 (please include all supporting clinical information) phone: 1-866-455-8416, option 4, option 4 High-tech Imaging and Utilization Management Programs: To request a prior authorization for High-tech Radiology, Office and Outpatient Cardiology, Outpatient Musculoskeletal (MSK) services and Radiation Oncology contact AIM Specialty Health: online: through the AIM ***Provider****Portal*$_{SM}$, available 24 hours a day, seven days a week through iLinkBlue (www.BCBSLA.com/ilinkblue). It is fully interactive, processing requests in real-time. phone: 1-866-455-8416 All other services that require an authorization: To request prior authorization for these services, download the Prior Authorization Form from the Blue Advantage Provider Portal. It is available on iLinkBlue at www.BCBSLA.com/ilinkblue, then click on "Blue Advantage" under the "Other Sites" section. For assistance with case management, notification and benefit determinations, contact the Blue Advantage Medical Management team at: phone: 1-866-508-7145, option 5, option 4 fax: 1-877-528-5816 1-877-528-5818 (for inpatient)
Behavioral Health	Blue Advantage members use New Directions Behavioral Health for their behavioral health needs. Inpatient and outpatient behavioral health authorizations should be submitted through the Behavioral Health Authorizations tool, available on iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Authorizations" menus option. phone: 1-877-250-9167 (for customer service and non-facility authorizations) mail: Blue Cross and Blue Shield of LA / HMO Louisiana, Inc. P.O. Box 7003 Troy, MI 48007

Service	Contact Information
Compliance/Fraud Waste and Abuse	To learn more about Blue Advantage's program, code of conduct and the provider's responsibility relative to the Compliance Program, including required training; reporting any suspected or actual violation of regulations, laws, policies or procedures or fraud, waste and abuse, go to the Blue Advantage Provider Portal at www.BCBSLA.com/ilinkblue. Click "Blue Advantage" under "Other Sites" >Helpful Links >Compliance Program: Compliance and Ethics Hotline: phone: 1-800-973-7707 fax: (225) 295-2599 email: compliance.office@bcbsla.com mail: Blue Advantage Compliance P.O. Box 84656 Baton Rouge, LA 70884-4656 Fraud, Waste and Abuse Hotline: phone: 1-800-392-9249
Dental	Blue Advantage members use United Concordia Dental (UCD) for their preventive dental coverage. Providers must be contracted directly with UCD to be in-network for members: phone: 1-866-445-5825 mail: (*claims address*) United Concordia Dental P.O. Box 69441 Harrisburg, PA 17106-9420
Disputes	For assistance related to contract disputes: phone: 1-866-508-7145 fax: 1-877-528-5820 mail: Blue Cross and Blue Shield of LA/HMO Louisiana, Inc. Attn: Provider Disputes P.O. Box 7003 Troy, MI 48007

Service	Contact Information
Fitness Program	Blue Advantage members may have fitness benefits (contingent on their plan type) through American Specialty Health (ASH). Members with this benefit can arrange for membership on their own for the following program: Sliver & Fit: phone: 1-877-427-4788
Network Development	For questions on how to join the Blue Advantage provider networks: phone: 1-800-716-2299, option 1 email: network.development@bcbsla.com
Pharmacy (for Part D Prescriptions)	Blue Advantage members with Part D use the Express Scripts, Inc. pharmacy network: phone: 1-800-935-6103/TTY:711 fax: 1-877-251-5896 mail: ESI – Attn. Medicare Reviews P.O. Box 66571 St. Louis, MO 63166-6571 online: www.covermymeds.com www.express-path.com For a comprehensive list of participating pharmacies, use the provider/pharmacy directory. www.BCBSLA.com/ilinkblue >"Blue Advantage" under "Other Sites" >Find a provider
Provider Credentialing & Data Management	Provider Credentialing & Data Management handles demographic changes as well as credentialing or recredentialing. To changes to your address, phone number, Tax ID number, etc., please us the Provider Update Form, located on our Provider Page (www.BCBSLA.com/providers >Resources >Forms). Credentialing packets and criteria are available on our Provider Page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks. For all other inquires: email: network.administration@bcbsla.com phone: 1-800-716-2299, option 2 (provider credentialing) 1-800-716-2299, option 3 (data management) fax: (225) 297-2750

Service	Contact Information
Provider Relations	For assistance with detailed and complex issues that have not been resolved through the Blue Advantage Provider Portal or by Customer Service: phone: 1-800-716-2299, option 4 email: provider.relations@bcbsla.com
Reference Laboratories	Send Blue Advantage members to a Blue Advantage network reference laboratory: Clinical Pathology Labs (CPL) phone: 1-800-595-1275 online: www.cpllabs.com Laboratory Corporation of America (LabCorp) phone: 1-800-255-8279 online: www.labcorp.com Quest Diagnostics phone: 1-866-MY-QUEST (1-866-697-8378) online: www.questdiagnostics.com
Vision	Blue Advantage members use Davis Vision for their routine eye care and vision services coverage: phone: 1-800-247-2814 mail: (*claims address*) Vision Care Processing Unit P.O. Box 1525 Latham, NY 12110

Service	Contact Information
Who Do I Contact if I Have Questions?	For claims status, member eligibility, benefit verification and care management questions that cannot be addressed through the Blue Advantage Provider Portal, Blue Advantage network providers may contact Blue Advantage Customer Service at 1-866-508-7145. For questions about Accountable Delivery System Platform (ADSP) training, accessing panel reports, financial incentive reports or care gap and RAF scores, contact provider.relations@bcbsla.com. If you are a Quality Blue Primary Care (QBPC) or Quality Blue Value Partnership (QBVP) partner, our Quality Blue teams are accountable for engaging with your practice/entity to share Blue Advantage quality performance updates. For questions about our Quality Blue programs, contact clinicalpartnerships@bcbsla.com. For non QBPC and QBVP questions specific to the Blue Advantage quality program, you may contact your Provider Relations Representative or send an email to provider.relations@bcbsla.com. If you are unsure of who your Provider Relations Representative is, please go to www.BCBSLA.com/providers >Provider Networks >Provider Support or call 1-800-716-2299, option 4.

Our Mission

To improve the health and lives of Louisianians.

Our Vision

To serve Louisianians as the statewide leader in offering access to afforable healthcare by improving quality, value and customer experience.

Our Goals

- Create a healthy Louisiana
- Make healthcare affordable for members
- Deliver the cutting-edge experience our customers expect
- Keep our company strong

General Information

Our Products

Blue Advantage (HMO) and Blue Advantage (PPO) offer Medicare recipients an excellent alternative to the options they currently have available with a comprehensive benefit package that covers more than traditional Medicare. Members have coverage available for a wide array of services, including outpatient prescription drug coverage, hospitalization and home care, preventive care services and ambulance transport, as long as the service is medically necessary and rendered by a participating provider. Blue Advantage members may be responsible to pay a copayment or coinsurance for some covered services. Blue Advantage is available to Louisiana residents statewide.

Provider Preclusion List

To ensure patient protections and safety, CMS will make available a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. This Preclusion List replaces the Medicare Advantage prescriber enrollment requirements. CMS made the Preclusion List available to MA Plans and Part D sponsors on January 1, 2019. Effective April 1, 2019, MA Plans and Part D sponsors are required to deny payment for a healthcare item or service furnished by an individual or entity on the Preclusion List.

Impacted providers or prescribers should receive an email and a letter from CMS in advance of inclusion on the Preclusion List. The letter will contain the reason for preclusion, the effective date of preclusion, and applicable rights to appeal.

For more information about this change, please see the Preclusion List homepage on www.CMS.gov.

Blue Advantage Member ID Cards

Blue Advantage provides each member with an identification (ID) card. This card contains demographic information about the covered member, as well as important coverage information such as copayment or coinsurance responsibilities and important phone numbers. Blue Advantage HMO members will also have their primary care provider's (PCP's) name and phone number listed on their ID card.

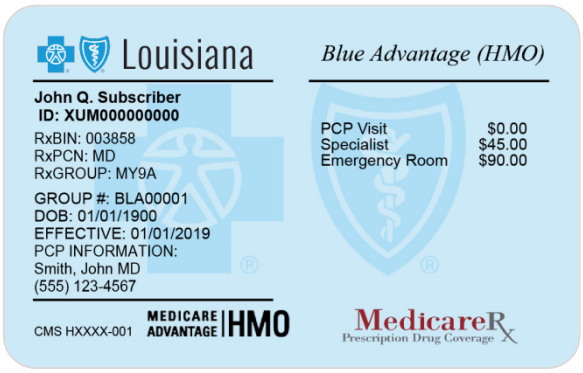
Blue Advantage encourages providers to make a copy of the members ID card for their records. We also encourage you to confirm if the member's insurance coverage has changed and if you are their PCP, each time you see them. The date on the card represents their effective date with the plan, not necessarily the effective date with the PCP.

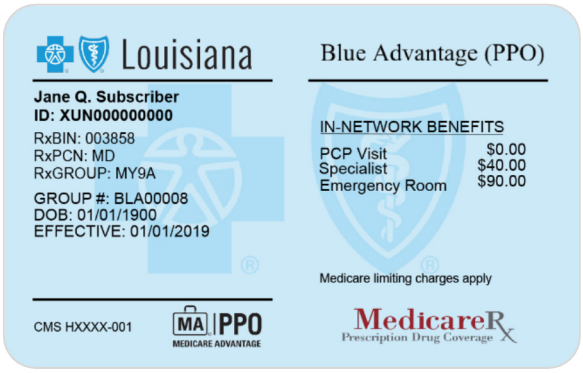
You may confirm member eligibility, current assigned PCP, maximum out-of-pocket and coordination of benefits (COB) information via our online Blue Advantage Provider Portal. It is the member's responsibility to present his or her member ID card at the time medical services are obtained. If your name is not listed on the

HMO member ID card as PCP, you can still see the member, and we will pay the claim. The member should contact Blue Advantage Customer Service to change their PCP of record.

Below are examples of Blue Advantage member ID cards. They are issued in the subscriber's name only. Blue Advantage member ID cards are used for all types of coverage:

Front View





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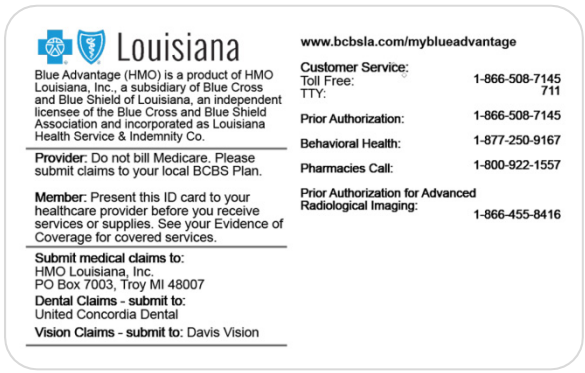


Blue Advantage Member Rights and Responsibilities

Each Blue Advantage member has the right to:

- Be treated with dignity, respect and fairness at all times.
- Receive advice or assistance in a prompt, courteous and responsible manner.
- Confidentiality. All information concerning enrollment and medical history is privileged and confidential except when disclosure is required by law or permitted in writing. Blue Advantage members are entitled to access their medical records according to state and federal law free of charge; and with adequate notice, they have the right to review their medical records with their provider. Blue Advantage members also have the right to ask plan providers to make additions or corrections to their medical records.
- Choose a Blue Advantage-contracted PCP. Members are asked to establish an ongoing relationship with their provider. Blue Advantage members have the right to change providers at any time and for any reason.
- Get appointments and services within a reasonable amount of time (see Appointment Scheduling and Waiting Time Guidelines section of this manual for more information).
- Participate fully in decisions about their healthcare and have providers explain things in a way they can understand. This includes knowing all treatment choices recommended for the condition, no matter what they cost or whether they are covered by Blue Advantage.
- Ask someone such as a family member or friend to help with decisions about healthcare. To have a guardian or legally authorized person exercise their rights on their behalf if their medical condition makes them incapable of understanding or exercising their rights.
- Make a complaint if they have concerns or problems related to coverage or care.
- Information about Blue Advantage, its services, its participating physicians and other healthcare providers providing care and members' rights and responsibilities.
- Discuss healthcare concerns or complaints about Blue Advantage with those responsible for their care or with Blue Advantage and to receive a response within a reasonable time period.

Cultural Competency

Cultural competency is a set of interpersonal skills that allows individuals to increase their understanding, appreciation, acceptance and respect for cultural similarities and differences, and to understand how these differences influence relationships and interactions with members. Members are entitled to dignified, appropriate and quality care, with sensitivity to cultural differences.

Network providers must ensure the following:

- Members understand that they have access to medical interpreters, signers and TTY services to facilitate communication without cost to them.
- Care is provided with consideration of the member's race/ethnicity and language and its influence on the member's health or illness.
- Office staff that routinely comes in contact with members has access to and participates in cultural competency training and development.
- Office staff that is responsible for data collection makes reasonable attempts to collect race and language specific information. Staff will also explain race/ethnicity categories to a member so the member is able to identify the race/ethnicity of themselves and their children.
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process.
- Office sites have printed and posted materials in English and all other prevalent non-English languages if required.

Member Orientation

Blue Advantage customer service representatives are available to assist members once they have enrolled in the plan. These representatives can provide a variety of information to the member. Members may contact Blue Advantage Customer Service with questions, regarding such topics as:

- The role of the PCP
- How to access a specialist
- Criteria for emergency room coverage
- Use of their member ID card
- Medical and prescription drug benefits

If you believe your patient is confused about their benefits or has general questions about the plan, you may call Blue Advantage Customer Service on the patient's behalf and request that a representative call the member to assist the individual. The contact information is in the Plan Information Contact List located in the front of this manual.

Credentialing Program

Participating providers are expected to cooperate with quality-of-care policies and procedures. An integral component of quality of care is the credentialing of participating providers.

This process consists of two parts:

- Credentialing
- Recredentialing

If a provider applies for participation in any of our networks, initial credentialing is required before being approved for participation. Our credentialing program consists of a full initial review of a provider's credentials at the time of application to our networks.

The credentialing packets and criteria are available on our Blue Cross Provider Page at www.BCBSLA.com/providers >Provider Networks >Join Our Network.

When a fully completed credentialing packet, agreement and required supporting documentation are received, the credentialing process can take up to 90 days. Our credentialing staff verify the provider's credentials including, but not limited to, state license, professional malpractice liability insurance, State CDS Certificate, etc., according to our policies and procedures and Utilization Review Accreditation Committee (URAC) standards.

We return incomplete or incorrect credentialing applications and stop the application process. The process starts over once all completed documents are received.

Providers will remain non-participating in our network(s) until the application has been approved by the Credentialing Committee.

Credentialing Committee

Blue Advantage and the Credentialing Committee review the provider's credentials to ascertain compliance with the following criteria. All participating providers must maintain these criteria (as applicable for provider type) on an ongoing basis:

- Unrestricted license to practice medicine in Louisiana as required by state law
- Agreement to participate in the Blue Cross networks
- Professional/malpractice liability insurance that meets required amounts
- Malpractice claims history that is not suggestive of a significant quality of care problem
- Appropriate coverage/access provided when unavailable on holidays, nights, weekends and other off hours
- Absence of patterns of behavior to suggest quality of care concerns

- Utilization review pattern consistent with peers and congruent with needs of managed care
- No sanctions by either Medicaid or Medicare
- No disciplinary actions
- No convictions of a felony or instances where a provider committed acts of moral turpitude
- No current drug or alcohol abuse

Based upon compliance with this criteria, Blue Advantage will recommend to the Credentialing Committee that a provider be approved or denied participation in our network(s). The Credentialing Committee, comprised of network practitioners, makes a final recommendation of approval or denial of a provider's application. The Credentialing Committee meets to review credentialing twice per month.

Facility Credentialing

Facilities requesting network participation must complete the initial facility credentialing application packet, which includes a checklist of required documents as well as the Health Delivery Organization (HDO) Information Form. Select facility types must also complete an HDO attachment:

- HDO Attachment A: Ambulance Company
- HDO Attachment B: DME Supplier or Pharmacy
- HDO Attachment C: Hospital, Ambulatory Surgical Center or Free-standing Skilled Nursing Facility
- HDO Attachment D: Urgent Care Clinic/Walk-in Clinic
- HDO Attachment E: Diagnostic Radiology (free-standing)
- HDO Attachment F: Retail Health
- HDO Attachment G: Laboratory
- HDO Attachment H: Outpatient Cath Lab

Blue Advantage has additional credentialing requirements specific to certain facility types:

Free-standing Diagnostic Imaging Facilities

Blue Advantage requires that all free-standing diagnostic imaging facilities and the equipment used for the modalities listed below be accredited by either the American College of Radiology (ACR) and/or the Intersocietal Accreditation Commission (IAC) as a condition for network participation. If a facility performs any or all of the modalities below and is not accredited or fails to remain accredited, they will be removed from all Blue Advantage networks in which they participate.

Accreditation is required to perform the following modalities:

- Magnetic resonance imaging (MRI)
- Computed tomography (CT)
- Positron emission tomography (PET)
- Nuclear Cardiology

An ***Opti****Net*® score of 80% or more for each modality is required. ***Opti****Net* is an AIM Specialty Health online registration tool for gathering modality-specific data on imaging providers in areas such as facility qualifications, technologist and physician qualifications, accreditation and equipment. This information is used to determine conformance to industry-recognized standards, including those established by the American College of Radiology (ACR) and the Intersocietal Accreditation Commission (IAC).

Blue Advantage reviews each provider's accreditation status during the provider's regularly scheduled recredentialing cycle. Providers are recredentialed by Blue Advantage within 36 months in accordance with URAC standards. Providers who do not maintain their accreditation or do not abide by Blue Advantage's credentialing guidelines will be subject to termination from any of our networks in which they participate. The only exception to this rule would be when a diagnostic imaging facility no longer performs a modality that requires accreditation or performs another modality that does not require accreditation.

This credentialing policy applies for freestanding (not hospital-based) diagnostic imaging facilities only.

Medical Staff

Only providers who are a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP) or Psychologist can be set up as a medical staff provider under the hospital agreement and file claims independently. All other providers are considered part of the hospital reimbursement and will not be set up independently under the hospital agreement.

Urgent Care Centers

For an urgent care center to participate in the Blue Advantage networks, it must be open at least until 8 p.m., Monday through Friday and open for a minimum of eight hours on either Saturday or Sunday.

Professional Credentialing

Professional providers requesting Blue Advantage network participation must complete the initial professional credentialing application packet, which includes a checklist of required documents as well as the Louisiana

Standardized Credentialing Application (LSCA). All providers, regardless of network participation, must include their NPI(s) on the application.

CLIA Certification Required

Professional providers who perform laboratory testing procedures in the office, are required to submit a copy of their CLIA certification when applying for credentialing or undergoing the recredentialing process.

Credentialing Process and Provider Specialty Network Provider Directory

As a network provider, you may only participate in the Blue Advantage networks and be listed in the network provider directory as the primary specialty you identified to Blue Advantage on your credentialing application. For example, providers may not participate in our networks as one of the following specialties of general practice, family practice, internal medicine or pediatrics unless they practice in a full PCP capacity. For more information on our credentialing process, visit our Blue Cross Provider Page.

Recredentialing

After the initial credentialing process, all network providers must undergo recredentialing within 36 months from the date of the last approval. The recredentialing process is conducted in the same manner as the initial credentialing process. Network providers are considered to be approved by the Credentialing Committee and recredentialed for another three-year cycle unless otherwise notified.

If a provider's network participation has been terminated, that provider may be required to reapply and complete the initial credentialing process before being reinstated as a participating provider in our networks.

Status Changes

A provider is required to report changes in their credentialing criteria to Blue Advantage within 30 days from the date of occurrence. Failure to do so may result in immediate termination.

iLinkBlue and Electronic Funds Transfer

iLinkBlue is our secure online tool for professional and facility healthcare providers. It is designed to help you quickly complete important functions such as eligibility and coverage verification, claims filing and review, payment queries and transactions. The iLinkBlue Application and Electronic Funds Transfer application are included in our credentialing packets. These documents are required to become a participating provider.

Subcontracted Providers

Subcontracted services are those services furnished to patients by providers other than the Member Provider while the patient is inpatient or outpatient. These services include, but are not limited to, EKG services, CAT scans, MRI, PET imaging, DME, technical components of clinical and anatomical lab, technical component of diagnostic services, etc.

The reimbursement outlined in the Member Provider Agreement is intended to cover all hospital services rendered to a patient, including those services that are performed by subcontracted providers. Subcontracted providers should seek payment solely from the Member Provider. Subcontracted providers should not bill Blue Advantage or the member for such services.

For those instances when Member Providers may need to send a member to another facility when the member is inpatient, the Member Provider should bill Blue Advantage for that service. The other facility should not bill Blue Advantage for the services rendered.

For example, a member, who is an inpatient at Main Street Hospital, needs hyperbaric oxygen therapy, but Main Street Hospital does not have the necessary equipment. Therefore, Main Street Hospital sends the member to Metropolitan Medical Center. Once the procedure is completed, the member returns to Main Street Hospital. In this case, Main Street Hospital should bill Blue Advantage for the hyperbaric oxygen therapy and reimburse Metropolitan Medical Center accordingly. Metropolitan Medical Center should not bill Blue Advantage or the member.

At least annually, Member Providers should furnish Blue Advantage with a listing of any subcontracted providers with whom the Member Provider has contracted to perform the Member Provider's duties and obligations under the Member Provider Agreement.

Provider Roles and Responsibilities

Non-discrimination Agreement

PHYSICIAN agrees: (1) not to deny, limit, condition, differentiate or discriminate in its provision of services to MA members because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, health status (which includes, but is not limited to, medical condition, including mental as well as physical illness, claims experience, receipt of healthcare, payor identity, medical history, genetic information, and evidence of insurability, including conditions arising out of acts of domestic violence), disability, source of payment, enrollees' complaint or grievance in connection with any evidence or certificate of coverage, age, or whether or not an MA member has executed an advanced directive; and (2) to render services to enrollees in the same manner, in accordance with the same standards, and within the same time availability as offered to non-plan patients consistent with existing medical ethical/legal requirements for providing continuity of care to any patient. Without limiting the generality of the foregoing, PHYSICIAN expressly agrees to comply with Title VI of the Civil Rights Act of 1964 and 45 C.F.R. 84; the Age Discrimination Act of 1975 and 45 C.F.R. 91; the Americans with Disabilities Act, and its amendments; the Rehabilitation Act of 1973; other laws applicable to recipients of federal funds; and all other applicable federal and state laws, rules and regulations. Without limiting the generality of the foregoing, PHYSICIAN shall make its services available to MA members on the same basis and time limits as those made available to patients who are not members of a plan (42 C.F.R. § 422.110).

Compliance Responsibilities for Blue Advantage Providers

As a Medicare Advantage Organization (MAO) with an established contract with the CMS, Blue Advantage is required to communicate its compliance program requirements to providers and ensure compliance with these requirements. Providers contracted with Blue Advantage to provide medical or administrative services to our members are required to comply with all applicable Medicare laws, regulations, reporting requirements and CMS instructions; with all other applicable federal, state and local laws, rules and regulations; to cooperate with Blue Advantage in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and to ensure that all healthcare professionals employed or under contract to render health services to Blue Advantage members, including covering physicians, comply with these provisions.

Blue Advantage requires written attestation of such compliance through its provider contracting process as well as through its contracted entity compliance training and education program. We may send written notification to providers and other contracted entities with a description of the compliance training and education requirements and a request to attest that our Code of Conduct, selected policies and procedures and other compliance-related documents (or their equivalents) are read, followed and distributed to any individuals employed or contracted by the entity to provide medical or administrative services to Blue Advantage Plan members. Upon request, your attestation of compliance must be completed within 60 days of notification.

Sanctions under Federal Health Programs and State Law

Network 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 Healthcare Programs are employed or subcontracted by the network provider.

As more fully stated in your contract, network providers must disclose to Blue Advantage whether the provider or any staff member or subcontractor has had any prior violation, fine, suspension, termination or other administrative action taken against them under Medicare or Medicaid laws; under any federal or state laws and regulations regarding the provision of medical services, by any insurer. Network providers must notify Blue Advantage immediately if any such sanction is imposed on the provider, a staff member or subcontractor.

Responsibility to Check for Exclusions

Medicare payment may not be made for items or services furnished or prescribed by a provider or entity that has been excluded by the Department of Health and Human Services Office of Inspector General (OIG) or General Services Administration (GSA). Providers have compliance responsibility for routinely verifying that no employees or contracted entities that perform administrative or healthcare service functions relating to Blue Advantage are excluded by the OIG/GSA and should immediately communicate any such exclusion to Blue Advantage Compliance Department.

Reporting Compliance Concerns

Actual or suspected Medicare program noncompliance, potential fraud, waste and abuse or any compliance concerns or violations relating to the Blue Advantage plan or its members must be reported. Providers must ensure that employees or contracted entities that perform administrative or healthcare service functions relating to Blue Advantage are aware of our expectations of reporting and its policy of non-intimidation and non-retaliation for good-faith reporting of compliance concerns and participation in the compliance program. Information about how to report compliance concerns can be found in the Plan Information Contact List section of this manual and should be publicized or otherwise made available throughout your facilities.

Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax or email. Providers and facilities are required to report the misrouted PHI to BCBSLA's Privacy Office at (225) 298-1652 or privacy.office@bcbsla.com, and destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI.

Professional Manner

Providers must offer services in a manner consistent with professionally recognized standards of care and in a culturally competent manner.

Provider and Member Communications

Providers must offer appropriate and adequate medical care to all Blue Advantage members. No action of Blue Advantage or any entity on thier behalf in any way relieves or lessens the provider's responsibility and duty to provide appropriate and adequate medical care to all members under the provider's care. Blue Advantage agrees that, regardless of the coverage limitations, the provider may freely communicate with members regarding available treatment options and nothing in this provider manual shall be construed to limit or prohibit open clinical dialogue between the provider and the member.

Preventive Health Guidelines

Preventive healthcare is a pinnacle component of our health plan and we endorse the guidelines that are outlined by the U.S. Preventive Services Task Force. This task force is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness and develops recommendations for clinical preventive services. It is important to realize that these recommendations are intended to establish an acceptable level of preventive care. Practitioners must use their own judgment in the care of individual patients. To ensure the most up-to-date guidance, please refer to the U.S. Preventive Services website or go to www.uspreventiveservicestaskforce.org/Page/Name/recommendations.

Guidelines for Providers When Discussing Medicare Advantage

Healthcare providers and their staff must remain neutral parties when discussing Medicare coverage options with their patients.

Healthcare providers and their staff **must not**:

- Offer Medicare Advantage and/or Part D sales/appointment forms to Medicare beneficiaries.
- Accept enrollment applications for Medicare Advantage plans and/or Medicare Part D plans.
- Make phone calls in regards to direct, urge or attempt to persuade Medicare beneficiaries to enroll in a specific plan based on financial or any other interests.
- Mail marketing materials to Medicare beneficiaries on behalf of Medicare plan sponsors.
- Offer anything of value to induce Medicare plan enrollees to select them as their healthcare provider.
- Offer inducements to persuade Medicare beneficiaries to enroll in a particular Medicare Advantage/Part D plan or organization.
- Perform health screenings in direct or indirect connection with the sharing of information about Medicare coverage options.

- Accept compensation directly or indirectly from a Medicare Advantage and/or Medicare Part D plan for beneficiary enrollment activities.
- Conduct or facilitate sales activities in patient service areas (i.e., exam rooms, waiting rooms).

Healthcare providers and their staff **are permitted** to:

- Distribute unaltered, printed materials created by CMS, such as reports from Medicare Plan Finder, the "Medicare & You" handbook, or "Medicare Options Compare" (from www.medicare.gov) including in areas where care is delivered.
- Provide the names of all plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Medicare Low Income Subsidy (LIS).
- Refer patients to plan marketing materials available in common areas.
- Answer questions or discuss the merits of a plan or plans, including cost sharing and benefits information. These discussions may occur in areas where care is delivered.
- Refer patients to other sources of information, such as State Health Insurance Assistance Program (SHIP) representatives, Plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website at www.medicare.gov, or 1-800-MEDICARE.

The Role of the Primary Care Provider (PCP)

PCP includes the provider specialities of family practice, general practice, geriatrics, internal medicine and pediatrics. These provider types must meet state requirements and be trained to give basic medical care. The PCP is to function within his/her scope of licensure or certification, has admitting privileges at a hospital and agrees to provide primary healthcare services to members 24 hours a day, seven days a week.

The PCP serves as the member's initial and most important contact for receiving medically necessary covered services. The PCP provides or coordinates care for each member. This includes:

- Maintaining continuity of care for all members by serving as PCP.
- Exercising primary responsibility for arranging and coordinating the delivery of medically-necessary healthcare services to members.
- Maintaining a current medical record for each member, including documentation of all medical services (PCP and specialty) provided to the member.
- Providing periodic physical examinations.
- Providing routine injections and immunizations.
- Providing or arranging 24 hours a day, seven days a week access to medical care.
- Assisting members to obtain needed specialty care and other medically necessary services.
- Arranging and/or providing necessary inpatient medical care at participating hospitals.

- Providing health education and information.
- Discussing Advance Medical "Directives" with all members as appropriate, and documenting in medical records (in a prominent place) if a member has executed a directive. In Louisiana, the directive may be referred to as a "Declaration."
- Maintaining records of periodic preventive services and providing appropriate timely reminders to members when services are due.

All member education materials encourage members to seek their PCP's advice before accessing medical care from any other source, except for emergency services.

PCP Patient Access

Blue Advantage encourages all new members to become established with their PCPs and not wait until they are sick or experience health problems. We understand that medical issues can arise prior to the member becoming established with the practice and those problems need to be addressed by the PCP's office until the initial appointment can be completed. It may be warranted to prepare front office personnel to ask appropriate questions of the member when they call, in order to triage and resolve the medical need(s) of the member.

Selecting a PCP

Blue Advantage members select a PCP at the time of enrollment. The member's PCP will be responsible for providing, coordinating and arranging all medically necessary services for the member. In rare cases, if the member has not identified a PCP and we cannot verify his/her choice, a PCP may be assigned. The member may select a different PCP by contacting Blue Advantage Customer Service. The contact information is in the Plan Information Contact List located in the front of this manual.

A PCP serves as the member's total care coordinator for non-emergent care. PCPs are available to members 24 hours a day, seven days a week through regular scheduling or on-call coverage. There will always be a doctor on call to help them.

Changing a PCP

It is important that members have a good relationship with their PCP, as they provide most of their care. Members can change their PCP to another Blue Advantage contracted PCP at any time for any reason. Members can do so by contacting Blue Advantage Customer Service. The contact information is in the Plan Information Contact List located in the front of this manual. The change will be effective the first day of the month following receipt of the member's request.

In rare situations, a member may be retroactively assigned to a PCP. For example, the member's PCP may have terminated the contract without notification because of illness or death.

We will assist the member in finding a new PCP as quickly as possible to promote continuity of healthcare and coverage, but there may be a slight time lapse that causes the assignment to have a retroactive effective date.

It is important to have office procedures in place for confirming member eligibility online on the Blue Advantage Provider Portal and to confirm that you are the PCP of record prior to a member's appointment.

Accountable Delivery System Platform (ADSP)

The ADSP is a web-based informatics application containing a set of tools designed to put information in the hands of contracted primary care providers. The information is provided in a series of reports and criteria-driven rules that allow a unique vantage point into the patient's health status across the entire continuum of care. The platform aggregates and analyzes data—including medical claims, EMR encounter data and lab and pharmacy data—to provide a comprehensive view of patient care. It then sends actionable clinical and financial data to physicians and other stakeholders at the point of medical decision-making to enable timely value-based healthcare decisions. This information is also intended to help monitor the patient population's chronic diseases and co-morbidities to improve patient outcomes and successfully practice medicine within a risk-adjusted Medicare reimbursement model.

Blue Advantage Provider Portal

The Blue Advantage Provider Portal allows Blue Advantage network providers access to information that assists in improving patient care and office efficiency. Providers in our Blue Advantage network must access and manage eligibility, benefits, claims and more electronically, through iLinkBlue. By accessing the Blue Advantage Provider Portal, providers will have access to:

- Blue Advantage Provider Administrative Manual
- Blue Advantage Provider Quick Reference Guide
- Blue Advantage Provider/Pharmacy Directory
- Blue Advantage Drug Formulary Search
- Member Eligibility Inquiry for Providers
- Claim Inquiry for Providers
- Authorization Inquiry
- Blue Advantage Provider Forms

To access the Blue Advantage Provider Portal, all network providers need an iLinkBlue username and password. If the provider does not have a valid iLinkBlue account, they must contact their administrative representative.

To obtain access to the Blue Advantage Provider Portal:

1. Log on to www.BCBSLA.com/ilinkblue.
2. Type your username and unique password in the password field.
3. Click "OK." If your username and password were entered correctly, your login should be successful.
4. The iLinkBlue main menu will be displayed.
5. From within iLinkBlue, click on "Blue Advantage" (under Other Sites).
6. Log in on the Blue Advantage Portal.

Administrative Representative

To access iLinkBlue and the Blue Advantage Provider Portal, providers must have a security administrative representative. To learn how to register your administrative representative with Blue Cross, visit www.BCBSLA.com/providers >Electronic Services.Accessing the ADSP

Access to ADSP is located within the Blue Advantage Provider Portal and available to primary care providers only.

Logon to www.BCBSLA.com/ilinkblue:

1. Click on "Blue Advantage" under the "Other Sites" section
2. Select the Blue Advantage Provider Portal option
3. Once logged into the Blue Advantage Provider Portal, there is a link to the ADSP

For ADSP training, you may email Provider Relations at provider.relations@bcbsla.com. Please include "ADSP training" in the subject line.

Accessing Provider Reports for PCPs

Between the 2nd and the 15th of each month, the administrative group level within the ADSP Portal for each PCP office will receive electronic files with reports including eligibility information, medical and pharmacy claims data, capitation and premium information, Blue Advantage news and updates. The administrative group level is then responsible to forward this information to each individual PCP office.

Daily Inpatient Hospital Census and Prospective Inpatient Admissions are available to all PCPs via their group's administrator.

Appointment Scheduling and Waiting Time Guidelines

All Blue Advantage network providers must use their best effort to adhere to the following standards for appointment scheduling and waiting time:

PCP—New patient	Within 30 days of the patient's effective date on the PCP's panel – to be initiated by the PCP's office
Routine care without symptoms	Within 30 days
Non-routine care with symptoms	Within five business days or one week
Urgent care	Within 24 hours
Emergency	Must be available immediately 24 hours per day, seven days per week via direct access or coverage arrangements
OB/GYN	1st and 2nd trimester within one week 3rd trimester within three days OB emergency care must be available 24 hours per day, seven days per week
Phone calls to the provider office from the member	Same day; no later than next business day

- Routine care without symptoms includes physical exams and well-woman exams.
- Non-routine care with symptoms includes rashes, coughs and other non-life-threatening conditions.
- Urgent care is defined as medical conditions that could result in serious injury or disability if medical attention is not received.
- Emergency is defined as medical situations in which a member would reasonably believe his/her life to be in danger or that permanent disability might result in the condition if not treated.

Practitioners should make every effort to see the patient within an average of one hour from the patient's scheduled appointment time. This includes time spent both in the lobby and the examination room.

Members who are late for their scheduled appointments may not be able to be seen within the hour.

Providers and suppliers are allowed to charge Medicare beneficiaries for missed appointments. Medicare itself does not pay for missed appointments, so such charges should not be billed to Medicare.

Capitation: Reporting Patient Encounters

Your agreement with Blue Advantage indicates, and CMS requires, that all patient encounters must be submitted via a claim, regardless of your reimbursement methodology. While the claims will appear on your weekly remittance notice once processed, identified by a "Y" on the claim line, payment for non-carve out services will be issued on a monthly basis separate from the remittance notice.

The Role of Specialists

Specialty care providers (specialists) deliver services beyond the scope of primary care to members. For members who have a PCP, the specialist is encouraged to coordinate care through the member's PCP.

Necessary prior authorizations must be obtained for hospital admissions or specified diagnostic testing procedures.

It is important for the specialist to communicate regularly with the PCP regarding any specialty treatment. Specialists are encouraged to report the results of their services to the member's PCP. The specialist should copy all test results in a written report to the PCP.

To help your Blue Advantage patients find specialists in their network, direct them to the Blue Advantage member website at www.BCBSLA.com/myblueadvantage >Providers >Find a Provider.

Verifying Member Eligibility for All Providers

We encourage all participating providers to use the Blue Advantage Provider Portal for standard member eligibility and plan benefit confirmation. This allows the Blue Advantage Customer Service to be available for more complex issues that cannot be handled via an automated process.

Providers can access current member eligibility online through the Blue Advantage Provider Portal. Your administrative representative (AR) has secure access and administrive rights to give others at your organization access to these additional features in the Blue Advantage Provider Portal.

At the beginning of each month, eligibility reports are sent to administrative PCP groups. Throughout the month, you may also check member eligibility online by going to www.BCBSLA.com/ilinkblue, then click the "Blue Advantage" menu option under "Other Sites." A secure logon will be needed to access this information.

Per CMS guidelines you will need four pieces of information to access/confirm member eligibility, including:

- Member's first name or initial
- Member's last name
- Member's Blue Advantage ID or Medicare Beneficiary Identifier (MBI), (typically 11 digits and an alpha character)
- Member's date of birth

In addition to eligibility, the Blue Advantage Provider Portal includes information such as:

1. Up-to-date member maximum out-of-pocket (MOOP)
2. The member's current PCP
3. Coordination of benefits (COB) information

Members have access to their eligibility through the Blue Advantage Member Portal.

Covering Physician Policy

PCPs with a capitation arrangement will be responsible for paying a covering physician for services that are rendered on their behalf so the covering physician will get paid fee for service.

If you are not a capitated PCP, then your covering physician will be able to submit a claim to Blue Advantage for payment. We stress that your physician be a contracted Blue Advantage provider.

Online Claim Inquiry for All Providers

Blue Advantage encourages all network providers to use the Blue Advantage Provider Portal for standard claims status checks. This allows the Blue Advantage Customer Service to be available for more complex issues that cannot be handled via an automated process.

Once a claim has been processed, it can be viewed on the Blue Advantage Provider Portal. A secure login is needed to access this information.

There are two ways you can inquire about a claim: 1) by date range or 2) by a specific claim ID.

For each listed claim, the screen displays the claim number, date(s) of service, provider, patient name, claim status, date of the claim status and payment amount. A detailed summary is provided for all finalized claims. Please note that if the status of the claim is "In Process" you will not be able to review in detail. The summary detail screen provides a brief summary, a payment detail and a summary of each line item.

Operations

Advance Directives

Members have the right of self-determination. An Advance Directive enables an individual to outline, in advance of a serious illness, what kind of treatment the person wants or does not want, should they become unable to decide or speak for themselves.

Because this is an important matter, members are advised to talk to family, close friends and their physicians before completing an Advance Directive.

The two most common forms of Advance Directives are a Health Care Directive (Living Will) and Durable Power of Attorney for Health Care.

A Health Care Directive is a document that allows individuals to state in advance their wishes regarding the use of life-prolonging procedures. It may be relied upon if individuals become unable to communicate their decisions. It is sometimes called a "Living Will." In most states, adults may complete and sign a pre-printed form or draw up their own forms.

A Durable Power of Attorney for Health Care is a signed, dated and notarized legal document that allows individuals to appoint someone to make healthcare decisions for them if they are not able to do so. These decisions may include instructions about any treatment they desire or those they wish to avoid, including decisions to withhold or withdraw life-prolonging procedures.

Blue Advantage participating providers are encouraged to ask their patients if they have an Advance Directive and are advised to place a signed, notarized copy of any Advance Directives in patients' medical records.

Individuals may change their minds or cancel either document at any time in accordance with state laws. Any change or cancellation should be written, signed and dated in accordance with the applicable state law and copies given to their healthcare providers.

If an individual wishes to cancel an Advance Directive while in the hospital, the individual should notify the treating physician, PCP, family members and others who may need to know.

In Louisiana, you can find further information, including advance directive forms, on the Office of the Attorney General State of Louisiana website at www.ag.state.la.us/.

Making Changes in Healthcare Coverage

Medicare restricts the number of times beneficiaries can voluntarily change their membership in a health plan. When a beneficiary is new to Medicare, the individual is given an Initial Coverage Election Period (ICEP) that allows the beneficiary to enroll in a Medicare Advantage plan. After the ICEP there is one primary time, the Annual Enrollment Period (AEP), when all Medicare beneficiaries may choose to make a change to the way they receive Medicare coverage. The AEP is the time when all beneficiaries should review healthcare and

drug coverage options for the upcoming year and are able to make changes that will be effective January 1 of the following year.

The Medicare Advantage Open Enrollment Period (MA OEP) is the time when anyone enrolled in a Medicare Advantage plan (except an MSA plan) can switch plans or return to Original Medicare (and join a stand-alone Medicare prescription drug plan).

Individuals may also qualify for what is called a Special Election Period (SEP). An SEP is a special timeframe outside the normal AEP when an individual may make a change to membership in a health plan, such as enroll in a new plan or request to disenroll from an existing plan. Examples of circumstances that warrant an SEP include but are not limited to the following: individuals who qualify for Medicaid benefits, individuals who get extra help (low income subsidy) and individuals who move out of the service area.

For more information on when changes can be made, see the enrollment table below. Please note that this is not an all-inclusive list of available SEPs.

Enrollment period	When?	Effective Date
Initial Coverage Election Period (ICEP) The beneficiary is given one ICEP when they are first eligible for both Medicare Part A and B. During this period a beneficiary may enroll in a Medicare Advantage Plan.	Starts three months before the beneficiary's first entitlement to both Medicare Parts A and B	Determined by the entitlement dates and the date the enrollment request is received
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes	From October 15 to December 7	January 1
Medicare Advantage Open Enrollment Period MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP.	From January 1 to March 31	First of the month following receipt of the enrollment request
Special Enrollment Periods (SEP) for limited special circumstances such as: • The beneficiary has a change in residence • The beneficiary has Medicaid • The beneficiary becomes eligible when they have, are getting or are losing their low income subsidy (LIS) • The beneficiary goes to live in an institution (such as a nursing home) • The beneficiary qualifies for a Qualified State Pharmaceutical Assistance Program (SPAP) • The beneficiary was a member of a special needs plan, but lost the special needs qualification required to be in that plan • The beneficiary has employer group coverage or is losing employer group coverage	Determined by the SEP	Determined by the SEP

Terminating a Relationship with a Patient

It is the provider's responsibility to do what he or she can to develop and maintain a positive patient-provider relationship. Blue Advantage will monitor Provider Member Terminations and will notify the peer review committee of any concerns of exploitation. In the event that such a relationship cannot be established, the steps outlined below are to be followed:

- Call the Blue Advantage Customer Service department and notify them that you are unable to establish and/or maintain a positive provider-patient relationship. Give your name and title, member's name and ID number and a phone or fax contact number where you can be reached. **Please do not send correspondence to the member terminating a relationship prior to approval by Blue Advantage.**
- The Customer Service department will transfer your contact information to the Quality Improvement (QI) Department, who will document your request and send you the checklist for communication of the termination reason.
- The checklist should be sent to the QI department within seven business days of initial contact. QI will return the checklist with either an approval and effective date or pending status due or denial to member in an acute care setting or under further review for compliance.
- Blue Advantage may choose to attempt contact with the patient/member prior to additional action by the provider office. You will be informed if this step is taken.
- You will be required to send a letter to the patient giving, in detail, the reason for terminating the relationship. The letter will include the effective date by which the patient is expected to make a PCP change, as provided to you from the QI department. The provider must allow the patient a MINIMUM of 30 days in which to find a new PCP. The patient will be effective with the new PCP the first day of the next month following the change. Until that time, the original PCP will be responsible for all aspects of the patient's healthcare needs.
- If the member does not choose a new PCP, Blue Advantage will assign the member to another PCP within the current PCP's region on a rotating basis. Blue Advantage will make every effort to successfully transfer the member to a new PCP by the date specified in the letter. Please note that the member will have the ability to pick another PCP within the PCP's overall group practice, but not within the specific practice of the terminating PCP.
- The existing PCP must assist in the "hand off" of the member by providing a copy of the complete medical file and directly discussing relevant care issues with the newly selected PCP. Please remember that when terminating a relationship with a patient, you are then asking a colleague to assume care of a patient with whom he or she may not be able to establish an effective relationship.
- **Please note** that a request to terminate the relationship with a patient must be based on an inability to establish and/or maintain an effective provider-patient relationship. A member may not be terminated from the provider's care based upon any of the following: (a) health status; (b) the cost of providing

services to the patient; (c) the termination of a family member; (d) the member being institutionalized or home-bound; (e) the member's ability to pay; or (f) nonpayment of any outstanding balance for services previously incurred.

- **PCPs cannot terminate members during an "acute episode" of care (i.e., hospitalizations or SNF stays).**
- Please notify Blue Advantage Customer Service Department, whenever a member is being disruptive or is abusing benefits. Blue Advantage will make every effort to assist the PCP and the member in developing and maintaining a positive relationship.
- Document specific behaviors that are interfering with the ability to establish and maintain a positive provider-patient relationship and retain any correspondence to and/or from the patient. Even though this may be an unusual situation, if you were in the process of terminating a patient prior to them becoming a Blue Advantage member, please notify the plan immediately so we can assist the member in securing a new PCP.

Medical Records

Blue Advantage has adopted guidelines for the maintenance of medical records within participating provider offices that support consistent and complete documentation of each member's medical history and treatment. Appropriate documentation is an essential component of quality care. Medical record guidelines and review procedures have been developed to comply with state, CMS and other nationally recognized standards. At a minimum, medical records must be retained for **10 years**.

The Blue Advantage Quality Management Committee has established the following minimum set of guidelines for a complete patient record. We may, from time to time, review a sampling of the provider's medical records to determine compliance with these guidelines. Whenever possible, we will give the practice at least 30 days' advance notice of medical record review.

Each medical record will be reviewed in relation to the following criteria:

- Medical record is organized and does not contain loose papers
- All sheets contain the patient's name, date of service and another unique patient identifier (DOB, MRN, etc.)
- Written entries are complete and legible
- Only standard medical abbreviations are used
- Each entry is dated and signed or initialed by the person making the entry. The reviewer must be able to identify the name and professional title of the person who made the entry.

- All charts must contain the following information:
  - Patient's identification information/demographics
  - List of allergies or a statement that the patient has reported no allergies
  - Problem list with dates of onset and resolution, including names of consulted providers, as applicable
  - Medication list, including diagnosis treated, and dates initially prescribed and discontinued, as applicable
  - Past medical history
  - Past surgical history or statement of nonePrevention check list, including age-appropriate immunizations, bone mass measurements and screenings for colorectal exams, mammograms, Pap smears/pelvic exams, prostate cancer exams and cardiovascular screening blood tests
  - Durable Power of Attorney for Health Care and Health Care Directive, or a statement that these documents were discussed with the patient
- Office visits document the following information:
  - Reason for the visit: chief complaint, as applicable
  - Pertinent biometrics and vital signs
  - History and physical examination pertinent to the reason for the visit
  - Assessment of the patient's health problem(s), including any medical history related to this episode of care that is not previously documented
  - Plan of treatment, including testing, referrals, therapies and health education to be provided
- All associated medical records, including specialist and/or ancillary reports, are signed and dated with any abnormalities addressed

Providers are expected to achieve an 80% score, at a minimum, on the medical record reviews. Medical records of providers scoring below this threshold will be re-audited in 180 days to ensure the documentation meets expected standards. Results of medical record reviews become part of the provider's profile. Deficiencies in medical record documentation are addressed through the Quality Management corrective action plan process and in collaboration with the physician.

Occasionally Blue Advantage may request medical record documentation to investigate a member grievance or appeal. In this event, the practitioner should respond within the timeframe stated in the request or within 10 calendar days of the date of the request.

Coding Support

All reported diagnoses must be supported by medical record documentation. A diagnosis can only be coded when it is explicitly spelled out in the medical record. Diagnoses must be clear enough to be abstracted by a competent professional coder. A list of diagnoses or complaints without indication of treatment, or assessment of current disease, specific signs, symptoms or status is inadequate and cannot be used for coding purposes. The record must contain evidence of evaluation and be linked to each diagnosis listed.

Coding Audits

Coding audits are conducted by certified coders to ensure that all diagnosis codes reported by the provider of service are appropriate based on supporting medical record documentation. Determination of the type of audit to be conducted is based on reported trends or risk areas, or issues identified upon review of claims, reports or specific diagnoses.

The coding department discusses audit results and provides details of specific coding/documentation concerns to the provider or the provider's group administration. In the event audit results are unfavorable, additional monitoring and a possible corrective action plan may be implemented, contingent upon the severity of the issue(s) identified.

New Technologies

Blue Advantage advocates the provider's freedom to communicate with patients regarding available treatment options, including medication alternatives, regardless of benefit coverage.

Blue Advantage also has a process for accepting requests from providers to consider new and emerging technologies and criteria. Such requests should be submitted with a letter outlining the medical necessity of the procedure or criteria and any medical documentation on the subject. Blue Advantage will determine if the new treatment or procedure is a covered benefit.

Please note that new and emerging technology must be a covered benefit under traditional Medicare before it can be approved for Blue Advantage members.

Requests for coverage of a new or emerging technology should be submitted in writing to Blue Advantage Customer Service, prior to providing or securing the service. The address and fax number are located in the front of this manual in the Plan Information Contact List.

Laboratory Tests

Blue Advantage network providers have the following options for lab work:

- Perform lab work in the office in accordance with the level of Clinical Laboratory Improvement Amendments (CLIA) certification
- Draw labs in the office and send specimens to one of our participating lab facilities identified in our Provider/Pharmacy Directory
- Send Blue Advantage members to a Blue Advantage network reference laboratory, which are listed in the Plan Information Contact List located in the front of this manual.

Physician Signature Guidelines

CMS guidelines mandate the presence of signatures specifically for all medical review purposes. Records pertaining to any procedures billed to Medicare Part B are potentially subject to review by not only Blue Advantage but also other CMS contractors. CMS allows the use of handwritten or electronic signatures.

Electronic signatures must be date and time stamped. Please note that the individual performing the service must be the provider who signs the documentation.

See next page for more information on signature guidelines.

Please adhere to the following guidelines to ensure that signature requirements are met:

Description	Signature Requirements	
	Met	Not Met
1. Legible full signature	X	
2. Legible first initial and last name	X	
3. Illegible signature over a typed or printed name Example:  John Whigg, MD	X	
4. Illegible signature where letterhead, addressograph or other information on page indicates identity of signature Example: an illegible signature appears on a medical record. The letterhead lists three provider names. One of the names is circled.	X	
5. Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a. A signature log or b. An attestation statement	X	
6. Illegible signature NOT over a typed/printed name and NOT on letterhead, and the documentation is unaccompanied by: a. A signature log or b. An attestation statement Example: 		X
7. Initials over a typed or printed name	X	
8. Initials NOT over a typed/printed name but accompanied by: a. A signature log or b. An attestation statement	X	
9. Initials NOT over a typed/printed name unaccompanied by: a. A signature log or X b. An attestation statement		X
10. Unsigned typed note with provider's typed name Example: John Whigg, MD		X
11. Unsigned typed note without provider's typed/printed name		X
12. "Signature on file"		X

Electronic Signatures

The following are examples of acceptable electronic signatures:

- Chart "Accepted by" with provider's name
- "Electronically signed by" with provider's name
- "Verified by" with provider's name
- "Reviewed by" with provider's name
- "Released by" with provider's name
- "Signed by" with provider's name
- "Signed before import by" with provider's name
- "Signed: John Smith MD"
- "Digitized signature:" Handwritten and scanned into computer
- "This is an electronically viewed report by John Smith MD"
- "Authenticated by John Smith MD"
- "Authorized by John Smith MD"
- "Digital Signature: John Smith MD"
- "Confirmed by" with provider's name
- "Closed by" with provider's name
- "Finalized by" with provider's name
- "Electronically Approved by" with provider's name
- "Signature Derived from Controlled Access Password"

The following are examples of unacceptable electronic signatures:

- Dictated but not read
- Signed but not read
- Auto-authentication
- Generated by

Record Corrections

Any correction, addition or change in any member's medical record made more than 48 hours after the final entry is entered in the record and signed by the provider, shall be clearly marked and identified as such. The date, time and name of the person making the correction, addition or change shall be included as well as the reason for the correction, addition or change.

Confidentiality of Medical Records

Medical records of members are confidential documents and must be treated as such to comply with state and federal laws and regulations. Providers must maintain the confidentiality of all information contained in a member's medical record and only release such records or information: a) in accordance with the provisions in the signed Provider Agreement, b) subject to applicable laws, regulations or orders of any court of law, c) as necessary, to other providers treating a member or d) with the written consent of the member.

Availability and Transfer of Medical Records

When members change PCPs, they may request a transfer of medical records or copies of medical records. These records must be forwarded to the member or to the new provider within 10 business days from receipt of the request.

Participating physicians and other providers, including facilities, are required to comply with Blue Advantage's Quality Improvement and Utilization Management activities. In many instances, this is accomplished by making medical records available to the health plan or its authorized agent. In addition, authorized representatives from CMS are allowed access to patient records of Blue Advantage members for specific purposes.

To facilitate this process, all members sign a release of medical information as part of their enrollment process. This release is in effect for the duration of their status as a Blue Advantage member:

> *I authorize any health professional or organization to provide to Blue Advantage or any of its affiliates, information related to medical history, care, treatment or consultation provided to me for the purpose of administering or coordinating the Medicare program.*

This release authorizes Blue Advantage access to members' medical records and to make copies as necessary. Blue Advantage will request, access and, if applicable, copy only the section or sections of the medical record that is necessary to make a coverage determination, pay claims and carry out other health plan benefit administration and quality management activities.

Transfer of Information Between Providers

Blue Advantage will educate network providers and their office staff on the following to promote continuity of care for Blue Advantage members:

Primary Care Providers: When a PCP refers a patient to a specialist, the PCP should forward relevant notes, X-rays, reports or other medical records to the specialist prior to the patient's scheduled appointment.

Specialists: Specialists should report preliminary diagnosis and treatment plans to the patient's PCP within two weeks from the date of the first office visit. The specialist should provide the PCP with a detailed patient summary report within two weeks after the completion of the evaluation or treatment and within two weeks of each subsequent encounter.

Confidentiality: Participating providers should ensure that medical record information transfers are performed in a confidential, timely and accurate manner that is consistent with applicable state and federal laws.

Terminating from Blue Advantage

While Blue Advantage makes reasonable efforts to resolve provider issues, contracted providers may voluntarily terminate their participation in the Blue Advantage network by **providing at least 90 days advance written notice per notification in your network agreement**.

Upon receiving a contract termination notice for a PCP or a specialist, Blue Advantage will close the PCP's panel to new members and notify affected members of the forthcoming contract termination. Blue Advantage will provide assistance, as needed, to transition care to another participating PCP or specialist. The resigning provider is responsible for the continued care of Blue Advantage patients during the 90-day notification period.

Blue Advantage may terminate the participation of an individual provider for cause. Blue Advantage gives notice in accordance with the terms of the Participation Agreement.

Changes in Your Practice

You must notify Provider Credentialing and Data Mangement in writing if you have any changes within your practice. A form entitled "Provider Update Request Form" can be found on the Blue Advantage Provider Portal and can be faxed, emailed and/or mailed.

Information that needs to be communicated includes, but is not limited to:

- Change of address, phone, fax or billing location
- Change in hours of operation

To report a change in your Tax ID number, use the Blue Cross Notice of Tax Identification Number (TIN) Change Form. To request network termination, use the Blue Cross Request for Termination Form.

These forms are available online at www.BCBSLA.com/providers >Resources. We will advise you if additional information is necessary to process your request.

Concierge Medicine

To ensure Blue Advantage is cost effective for our senior member population, we do not consider concierge providers for Blue Advantage network participation. Should you change your practice to concierge medicine, you must submit notice of this change and will be terminated from Blue Advantage network participation. This change does not affect your participation in our other provider networks.

Fraud, Waste and Abuse

Blue Advantage defines fraud, abuse and billing error as follows:

- Fraud is the knowing and willful deception, misrepresentation or reckless disregard of the facts with the intent to receive an unauthorized payment.
- Waste is the overuse of services that, directly or indirectly, results in unnecessary costs.
- Abuse is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss to the plan. Abuse usually does not involve a willful intent to deceive.

Work Related Issues

Employment Requests – the plan will not cover tests needed for purposes of employment only (with no medical necessity). The requesting provider will need to submit the pre-service request to the plan for approval/denial rights to be given to the member.

Workers' Compensation Claims

If you believe that a Blue Advantage patient requires treatment for a work-related illness or injury, ensure he/she has contacted the employer to report the condition in accordance with the State Workers' Compensation Law. Claims for your treatment of this patient's work-related illness or injury should be billed to the employer or the employer's Workers' Compensation insurer. Blue Advantage *Evidence of Coverage* specifically excludes work-related illnesses and injuries.

If the patient's employer or the employer's Workers' Compensation insurer denies reimbursement for your services, you should advise the patient of that fact. The patient may elect to be treated by a provider who the employer or its insurer designates to treat such work-related conditions or to pay for your services on a fee-for-service basis and then seek reimbursement from the employer or insurer. In any case, it is important to follow Blue Advantage authorization procedures so that if the employee successfully contests the issue, you will be reimbursed.

Priority Right of Recovery (Subrogation)

In situations involving settlements to beneficiaries paid by liability insurance, no-fault insurance and uninsured or underinsured motorist insurance that provides payment based on legal liability for injury or illness or damage to property, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance Section 1862 (b) of the Social Security Act grants Medicare a priority right of recovery will be done. Section 1862 (b) also gives the Medicare program the right of subrogation for any amounts payable to the program under the Act.

Therefore, Blue Advantage, operating a Medicare Advantage contract, has the same right of recovery. Blue Advantage's right to recover its benefits takes precedence over the claims of any other party, including Medicaid.

Claims that contain potential third-party liability (TPL) will be paid by Blue Advantage on a conditional basis, which permits us to recoup any payments if/when a settlement is reached.

Medical Management

Blue Advantage affirms:

- Utilization management decisions are based only on appropriateness of care and service and existence of coverage.
- Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or care.
- Financial incentives for utilization management decision makers do not encourage decision that may result in underutilization.
- Incentives are not used to encourage barriers to care and service.
- Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Provider Quick Reference Guide

To determine services that require prior authorization or notification, please refer to the Provider Quick Reference Guide and the Durable Medical Equipment/Orthotics & Prosthetics list, available on the Blue Advantage Provider Portal. These lists are updated periodically, as applicable.

Benefit Determinations

The Medical Management department is responsible for administering authorizations, medical necessity determinations and monitoring the appropriateness and efficiency of services rendered. Certain services require an authorization to confirm that the member's PCP and Blue Advantage has approved the member's specialty care services. Blue Advantage uses the following resources for benefit and medical necessity determinations:

- Member's Evidence of Coverage (EOC) and Summary of Benefits
- Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Medicare Managed Care Manuals
- BCBSLA/Lumeris Medicare Advantage criteria documents
- BCBSLA Commercial policies, when no CMS coverage documents exist for a certain service
- InterQual®
- Hayes Health Technology Website
- CMS Designated Medical Compendia
- AIM Specialty Health®

Patient-specific information is needed by Blue Advantage to determine the medical necessity and member's benefit for a requested procedure. This information includes:

- ICD-10 diagnosis and procedure codes, as applicable
- Prior procedures/testing/treatments that have been tried and failed (include supporting documentation, photos, if applicable)
- Plan of treatment
- Requested service description (include CPT® and HCPCS codes)
- Expected outcome

If the request is for Blue Advantage (HMO) out-of-network services, also include:

- The reason the member needs to go out-of-network
- The name of network providers who have been consulted
- The medical records from the requesting physician and consulting physicians

Please send all requests for benefit determinations to Blue Advantage Medical Management, at the address or fax noted in the Plan Information Contact List in the front of this manual or call the Medical Management department to make a request.

For information regarding members' benefit plans and coverage, you may consult the Summary of Benefits and Evidence of Coverage documents placed on the Blue Advantage Provider Portal, accessed through iLinkBlue (www.BCBSLA.com/ilinkblue). Click on the "Blue Advatange" link under the "Other Sites" section.

Prior Authorizations and Notifications

Prior authorization is the process of collecting information in advance of authorizing the non-emergency use of facilities, diagnostic testing and other services before care is provided.

To request a prior authorization of items or services, providers may contact Medical Management by phone or fax. The contact information is in the Plan Information Contact List located in the front of this manual and the Provider Quick Reference Guide. The phones are forwarded to a secure voice mail system during non-business hours. Calls received after hours or on the weekend are returned on the next business day. The fax is available 24 hours a day, seven days a week. Please allow up to 14 days for a standard decision and 72 hours for an expedited decision to be rendered, although decisions will be made as expeditiously as the member's health condition requires.

The prior authorization process permits advanced eligibility verification, determination of coverage and communication with the requesting provider or member. Prior authorization also allows Blue Advantage providers to identify members for pre-service discharge planning and case management.

Prior authorizations are accepted by telephone, online authorization portal or fax, with a review conducted by a representative of the Medical Management department, Medical Director or Board-Certified Specialist. In each case, the review ensures that coverage for the services are included in the individual's benefit plan, that

services are provided at the most appropriate level of care and site, and that the services are medically necessary. Only the Medical Director (or clinical reviewer designee) may determine a denial of services based on medical necessity. Providers may request criteria used to make a medical necessity dertermination by calling the Medical Management Department.

Outpatient Surgical Procedures and Elective Hospital Admissions Requiring Prior Authorization

Providers must contact Medical Management at least 14 days prior to the procedure. If a previously authorized elective service is canceled, Blue Advantage Medical Management must be notified of that cancellation and the rescheduled date, if applicable.

A new authorization may be required if the authorized health service requested has not been delivered within the time frame specified in the authorization.

Blue Advantage's decision regarding an authorization is an organization determination. Blue Advantage's decision is never intended to limit, restrict or interfere with the provider's medical judgment. In all cases, decisions regarding treatment continuation or termination, treatment alternatives or the provision of medical services are between provider and patient.

Notification is the act of providing notice or alerting Blue Advantage of a particular service provided to a Blue Advantage member. The notification process permits eligibility verification, communication with the PCP and/or member, identifies members for concurrent review, pre-service discharge planning and case management. The Blue Advantage Medical Management department will accept verbal notification from the scheduling specialist, the facility or the PCP.

Other Services that Require Authorization

Outpatient observation: Providers must contact Medical Management within one business day of admission and discharge and fax discharge summary/visit summary once the member is discharged.

Observation services must also be reasonable and necessary to be covered. Notification to Medical Management is required for all outpatient observation services within one day of admission and one day of discharge, with discharge summary faxed or similar patient education/follow-up information. Claims for observation services will not be paid if timely notification is not made.

Emergency hospital admissions: Providers must contact Medical Management within one business day. If an admission changes from observation to inpatient, the provider must notify Medical Management within one business day.

Providers can report observation cases and emergent hospital admissions to Medical Management. The contact information is in the Plan Information Contact List located in the front of this manual. The phones are forwarded to a secure voice mail system during non-business hours. The fax is available 24 hours a day, seven days a week. Notifications submitted via phone or fax will be confirmed by Blue Advantage Medical Management staff with a reference number. This reference number does not guarantee payment.

The notification process serves to:

- Confirm the admission is authorized by the primary care provider, if applicable
- Verify member eligibility
- Screen for coverage/benefit exclusions
- Identify if the facility is a Blue Advantage contracted facility
- Notify the appropriate Blue Advantage Utilization Case Manager of the admission (hospital) to begin review of continued stay appropriateness and early identification of potential discharge needs
- Improve care coordination efforts and provide effective care transitions to plan membership

Upon issuing a reference number for a hospital admission, providers are instructed to submit clinical documentation to Blue Advantage within one business day of admission to complete the notification process and receive an authorization for payment. The clinical information provided enables Blue Advantage Utilization Management to initiate the concurrent review process (see the Initial, Concurrent Review and Discharge Planning Section).

Inpatient admissions and outpatient surgical procedures that have received authorization are eligible for payment by Blue Advantage as long as all other requirements have been met. Blue Advantage is not obligated to pay claims on an authorization number for the following situations:

- Those who are not Blue Advantage members at the time of service.
- Those who fail to meet other eligibility criteria.
- Those who receive care determined not to be medically necessary.
- Claims that may be denied based on claims-editing logic.

Providers who are denied payment because notification/prior authorization is lacking may not bill the member. Provider pay disputes should be submitted to the plan in writing. Your request should outline the basis for the dispute and should include documents supporting your position. Please send your written claims dispute requests with all supporting documentation to Blue Advantage Correspondence. The address is located in the front of this manual.

Radiation Oncology Program

The Radiation Oncology Program reviews certain treatment plans against clinical appropriateness criteria to help ensure that care aligns with established evidence-based medicine. To request review of treatment plans, providers should contact AIM Specialty Health® (AIM) for review of the radiation therapy modalities and services. The AIM ***Provider****Portal*$_{SM}$ can be accessed through iLinkBlue (www.BCBSLA.com/ilinkblue). Information on how to contact AIM for an authorization is available in the front of this manual. See the Quick Reference Guide for the list of services that must be pre-service reviewed by AIM.The program design includes both prospective and retrospective, case reviews for the services requiring authorizations for up to two days

after the date of service. The goal is for physicians to obtain pre-service review of their requests; however, there are circumstances that may prevent the physician from submitting a case pre-service when a retrospective review will occur.

All providers must contact AIM to obtain pre-service review for non-emergency, outpatient radiation therapy modalities. Radiation therapy performed as part of an inpatient admission is not part of this AIM program.

Voluntary Notification for 3-D Conformal Radiation Therapy (EBRT)

For 3-D Conformal Radiation Therapy (EBRT), pre-service review is required only for procedures involving bone metastases and breast cancer. Additionally, Blue Advantage is requesting that ordering providers contact AIM to review all other EBRT requests on a voluntary basis.

Cardiology Program

This program supports care that is appropriate, safe and consistent with evidence-based medicine. AIM Clinical Appropriateness Guidelines for the cardiology program are available online at www.aimspecialtyhealth.com, click on "Download Now" and then "Cardiology."

This program applies for non-emergent cardiology services performed in an office or outpatient setting. Cardiology procedures needed for emergency situations will not be subject to review under this program.

Services included in the Cardiology program are:

- Diagnostic:
  - Echocardiography
  - Coronary arteriography/cardiac catheterization *(Note: Coronary arteriography/cardiac catheterization for management of acute coronary syndrome is excluded from this program)*
  - Arterial ultrasound
- Interventional Services:
  - Percutaneous coronary interventions (PCIs) such as coronary stents and balloon angioplasty

Musculoskeletal (MSK) Program

This program supports care that is appropriate, safe and consistent with evidence-based medicine.

This program applies for non-emergent MSK services performed in an ambulatory surgical oroutpatient hospital. MSK procedures needed for emergency situations will not be subject to review under this program. Services included in the MSK program are:

- Spine Surgery – cervical, thoracic, lumbar and sacral (including all concurrent spinal procedures and all associated revision surgeries):
  - Bone grafts

- Bone growth simulators
- Cervical/lumbar spinal fusions
- Cervical/lumbar spinal laminectomies
- Cervical/lumbar spinal discectomies
- Cervical/lumbar spinal disc arthroplasty (replacement)
- Spinal deformity (scoliosis/kyphosis)
- Vertobroplasty/kyphoplasty

- Interventional Spine Pain Management
  - Epidural steroid injections
  - Facet injections
  - Spinal cord stimulators
  - Radiofrequency ablation
- Joint Surgery
  - Joint replacement (Hip, Knee & Shoulder)
  - Arthroscopy and open procedures (Shoulder & Knee)
  - Hip arthroscopy
  - Meniscal allograft transplantation of the knee
  - Treatment of osteochondral defects

Ambulatory Surgical and Outpatient Hospital MSK Authorizations:

AIM Clinical Appropriateness Guidelines for the MSK program are available online at www.aimspecialtyhealth.com, click on "Download Now" and then "Musculoskeletal."

To initiate prior authorizations, access the AIM ***Provider****Portal*$_{SM}$ through iLinkBlue (www.BCBSLA.com/ilinkblue) under the "Authorizations" menu option, or by calling AIM directly at 1-866-455-8416.

Inpatient Hospital Authorizations:

Blue Advantage Medical Necessity Criteria can be found online on the Blue Advantage Provider Portal. Click "Medical Necessity Criteria" to access the CMS-criteria search links. The Blue Advantage Provider Portal is available through iLinkBlue (www.BCBSLA.com/ilinkblue).

To initiate prior authorizations, fax requests with all supporting clinical information to Blue Advantage Medical Management. Please allow up to 14 days for a determination.

Initial, Concurrent Review and Discharge Planning

Initial and concurrent review encompasses those aspects of patient care management that take place during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. All reviews are conducted electronically, by phone or via fax utilizing InterQual® medical necessity review criteria and Medicare guidelines. Requests for urgent concurrent cases will be completed and the facility notified within 72 hours of receipt, as long as all required information is submitted with the request.

The concurrent review process includes the following activities:

- Collection of necessary information from providers and facilities concerning the care provided to members.
- Assessment of the clinical condition and ongoing medical services and treatments to determine benefit coverage and medical necessity.
- Identification of continuing care needs to facilitate discharge to the appropriate setting.
- Discharge planning and coordination.

To facilitate initial and concurrent review and discharge planning, facilities are required to perform the following activities:

- Provide clinical information to Blue Advantage Medical Management upon one business day of admission to obtain an initial authorization.
- Provide updated clinical information as requested by plan staff within one business day of request to obtain authorization for days beyond the initial length-of-stay authorization.
- Provide anticipated discharge dates to Blue Advantage Medical Management to issue final length-of-stay authorization for claims payment and ensure effective and appropriate coordination of after-care services.

Using InterQual® medical necessity review criteria and Medicare guidelines, the clinical reviewers perform prospective review for requests for:

- Extended-care facility
  - rehabilitation hospital
  - long-term care hospital (LTAC)
  - skilled nursing facility (SNF)
- Home health services
- Concurrent review for continued care reviews for:
  - acute hospital

- rehabilitation hospital
- LTAC and SNF
- home health

The clinical reviewers also perform retrospective requests for emergent inpatient services provided by out-of-network facilities.When the clinical review demonstrates the criteria are not met, the case is referred to a Blue Advantage medical director for review.

The plan will authorize the services based on whether the services meet all of the following conditions:

- The services are appropriate given the symptoms and member's medical history and are consistent with the diagnosis. "Appropriate" means the type, level and duration of services and setting are necessary to provide safe and adequate care and treatment;
- The services are rendered in accordance with Medicare and professionally recognized standards;
- The services are not generally regarded as experimental or unproven by recognized medical professionals or appropriate governmental agencies; and
- The services are permitted by the licensing statutes that apply to the provider who renders the services.

If a member's condition is not appropriate for admission according to the criteria or the member's condition has improved or stabilized to the point where acute inpatient care is no longer necessary, the utilization case manager helps coordinate arrangements to transition the member to an alternative level of care. The utilization case manager will communicate with the facility's utilization review and social services regarding the member's future needs. Once the attending physician has communicated what is needed to facilitate the discharge of the member, the utilization case manager coordinates decisions on elements including transfer to other facilities, ordering DME, home health care and other post-hospitalization services. A completed discharge summary, including disposition and discharge medication list, should be sent to Medical Management at time of discharge.

Complex cases, which require the advice of the medical director, will be referred for immediate review. When medically appropriate, observation care is an option for patients whose problems are reasonably expected to be resolved within 24 to 48 hours. Observation care includes ongoing short-term treatment, assessment and reassessment that is provided while a decision is being made regarding whether the patient will require further treatment as a hospital inpatient or if they are able to be discharged from the hospital.

Peer-to-peer Consults with the Medical Director

For any adverse concurrent review determination, including observation status in place of "inpatient" or level of care, the peer-to-peer process is available. Attending providers may request a peer-to-peer discussion with the physician reivewer at any time during the inpatient stay and for up five calendar days after discharge. To facilitate this discussion, please contact the plan's utilization case manager for your facility. Blue Advantage

will not recondsider its decision without cause or without a peer-to-peer request, unless the providers contract states otherwise.

Notice of Discharge from an Inpatient Facility, Home Health or Comprehensive Outpatient Rehabilitation Facility (CORF)

The Important Message from Medicare (IM) is an existing statutorily required notice designed to inform Medicare beneficiaries that their covered hospital care, home health or comprehensive outpatient rehabilitation is ending. The physician who is responsible for the member's inpatient hospital care must make the decision that discharge is appropriate. The IM must be given to the member within two days of discharge.

The Notice of Medicare Non-Coverage (NOMNC) is issued to Blue Advantage members notifying them that their skilled services, home health care or CORF services are ending. Per CMS guidelines, the NOMNC must be given to the member and/or their identified representative a minimum of two days prior to discharge even if they agree the service should end. A signed NOMNC must be faxed to Blue Advantage Medical Management.

Both of these forms are located on the Blue Advantage Provider Portal.

The member's appeal rights are included in both the IM and NOMNC forms.

Medicare Outpatient Observation Notice (MOON)

CMS requires all hospitals to notify Medicare enrollees, including MA members, of their status as an outpatient receiving observation services. The Medicare Outpatient Observation Notice (MOON) is a standardized notice developed to inform members that they are not an inpatient of the hospital or critical access hospital (CAH) and the implications of outpatient observation status with regard to cost-sharing and eligibility for skilled nursing facility (SNF) coverage.

Hospitals and Critical Access Hospitals (CAH) are required to furnish the MOON to Medicare beneficiaries when a member is in observation setting for 24 hours or more, if the member has not already received the form prior to being admitted for observation.

The notice must be provided no later than 36 hours after emergency department or observation services are initiated or, sooner, if the member is transferred, discharged or admitted.

Network and Out-of-network Providers

Blue Advantage strives to provide a comprehensive network of providers to meet our members' healthcare needs. Participating providers help ensure the affordability and success of their patients' healthcare by referring them to participating network providers. In rare instances, a patient may have a medical need for a non-emergent service that cannot be met by a network provider. If the contracted providers are unable to refer to a network provider, prior authorization from the Medical Management department will be required before the patient can be referred to a non-participating provider, for members enrolled in the Blue Advantage (HMO) plan.

Blue Advantage (PPO) plan members do not require prior authorization to obtain services out-of-network. If a contracted provider wishes to refer to an out-of-network (OON) provider, the referring contracted provider must contact the Blue Advantage Medical Management department at the number in the front of this manual. Medical Management will perform the following activities:

- Confirm the provider is OON.
- If OON, search the provider/pharmacy directory to determine if there is an in-network specialist of the same type as being requested within a 20-mile radius of the member's residence. If there is not, the OON request is approved.
- If there is an in-network specialist, Medical Management requests the referring contracted provider's office to withdraw the request for the OON specialist and redirect to an in-network specialist.
- If the referring contracted provider does not want to redirect, they are asked to send in clinical information to Medical Management to support the need for the OON specialist.
- If clinical information is sent, it is reviewed against Transition of Services criteria. If it does not meet criteria, the request is sent to the medical director for review. All parties are notified in writing of the plan's decision.

Transition of Services criteria:

- With the exception of transplant services, the services requested are not available from contracted providers within a 20-mile radius.
- Dialysis, until the member can be transitioned to a participating provider or up to a period of 60 days from the effective date for new members or from the time the member's provider terminated from the network. Newly-diagnosed or relapsed cancer in the midst of a course of treatment (radiation or chemotherapy).
- Members who are a recipient of an organ or bone marrow transplant and are within a year post-transplant.
- Current hospital confinement.
- A terminal illness, for the length of the terminal illness.
- Performance of a scheduled surgery or other procedure that has been authorized by the plan, as part of a documented course of treatment and is scheduled to occur within 30 days of the provider's contract termination date or the effective date of coverage for a new member.
- A pregnancy in the second or third trimester on the member's effective date and the immediate post-partum period.

Non-emergent, out-of-network services will not qualify for coverage unless they are authorized prior to services being rendered by Blue Advantage's Medical Management department.

Initial Organizational Determination (IOD)

Whenever a member contacts Blue Advantage to request a service, the request indicates that the member believes that Blue Advantage should provide or pay for the service. Thus, the request constitutes a request for a determination and Blue Advantage's response to the request constitutes an organization determination. However, if a provider declines to give a service that a member has requested or offers alternative services, this is not an organization determination (the provider is making a treatment decision). In this situation, the member must contact Blue Advantage to request an organization determination for the service in question or the provider may request the organization determination on the member's behalf.

When there is a disagreement with a provider's decision to deny a service or a course of treatment, in whole or in part, the member has a right to request and receive an organization determination from Blue Advantage regarding the services or treatment being requested. Blue Advantage is required to make an independent decision in these matters and will request medical records in order to make that decision. All parties will be notified in writing of the plan's decision.

Adverse Initial Organizational Determination Process

An adverse determination is a decision by the plan or its designee that an admission, availability of care, continued stay or other healthcare service has been reviewed and, based upon the information provided, does not meet the plan's requirements for coverage. These requirements include medical appropriateness and necessity, appropriate healthcare setting/level of care or quality and effectiveness of care. As a result of not meeting these requirements, the coverage for the requested service is subsequently denied or reduced. Blue Advantage provides an appeal process for members in the event of an adverse determination.

For adverse decisions on pre-service requests, Blue Advantage offers a peer-to-peer discussion to the requesting provider. This discussion is not an appeal, and the member or member's representative can appeal the adverse decision by following the directions on the accompanying denial notice.

Adverse determinations of requested services made in the course of the review process are communicated verbally or via fax to the requestor within one business day from when the determination is made. This communication is confirmed in writing via the Integrated Denial Notice (IDN) within three days of the oral communication. A copy of the Integrated Denial Notice is included in the "Forms" section of this manual. This notification is sent to the patient or responsible party, the physician and facility (if applicable). The reason(s) for the adverse determination of requested services, available alternatives and the appeal rights and procedures are included in the notices of denial. Blue Advantage members must receive this determination within 14 days of service request, unless an expedited determination is necessary. Other levels of the member's appeal process are addressed in the Blue Advantage Evidence of Coverage.

Expedited Member Appeals

Expedited appeals for requested services pertain to those services in which the standard appeal time period (30 days) could seriously jeopardize the member's life, physical or mental health or the member's ability to

regain the maximum function. Blue Advantage must resolve an expedited review within 72 hours or as expeditiously as the member's physical or mental health requires. An expedited appeal can be made by the member or provider on behalf of the member.

Health Risk Assessments

Blue Advantage sends a Health Risk Assessments (HRA) to each member upon confirmation of the member's effective date from CMS. These HRAs are analyzed in order to identify those members who have complex or serious medical conditions. When a member is identified as high-risk, the information gathered through the HRA is forwarded to the PCP for inclusion in the patient's record. The PCP is expected to conduct an assessment, establish and implement treatment plans appropriate to the condition and monitor each case on an ongoing basis.

Clinical Trials

There are certain requirements for Medicare coverage of clinical trials. Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage (MA) plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials. Blue Advantage pays the enrollee the difference between original Medicare cost-sharing incurred for qualified clinical trial items and services and Blue Advantage's in-network cost-sharing for the same category of items and services. When a member is in a clinical trial, the member may stay enrolled in Blue Advantage and continue to get the rest of their care that is unrelated to the clinical trial through Blue Advantage. In addition, if plan guidelines are followed, a member may be made whole financially for the difference between the original Medicare member cost share and the Blue Advantage cost share for identical benefits. Please supply documentation such as the Medicare provider remittance notice or the member's Medicare summary notice along with the claim as this shows the amount of member cost share incurred.

If you have a patient that you intend to refer for a clinical trial, please notify Blue Advantage's Medical Management department prior to enrolling the member in the clinical trial or providing service related to the clinical trial. Modifiers Q0 and Q1 should be billed, if applicable.

Behavioral Health and Substance Abuse Services

Blue Advantage is partnered with New Directions for their expertise in the provision of behavioral health services. To arrange for care, the provider or member may call New Directions. The contact information is in the Plan Information Contact List located in the front of this manual. No referral is needed; Blue Advantage (HMO) members must be directed to and seen by a provider within the Blue Advantage network to receive covered services. Blue Advantage (PPO) members may be seen by a provider outside the Blue Advantage network. However, the member may incur additional costs.

Participating providers include:

- Professional counselors and psychologists
- Psychiatrists
- Psychiatric nurses and social workers
- Facilities for inpatient and outpatient care including rehabilitation

New Directions medical necessity criteria are the basis for all behavioral health utilization decisions. Criteria may be found on the New Directions website at www.ndbh.com under the "Providers" section.

New Directions has a team of behavioral health professionals who are available 24 hours a day, seven days a week to assist in obtaining the appropriate level of care for your patients.

Case Management

As a partner in managing the health needs of our members, Blue Advantage offers a variety of case management services that are available through referral by their PCP, providers, discharge planners, plan staff or upon self-referral. The plan also reaches out to high-risk members. These services are available at no charge to all members not enrolled in a hospice program or residing in a long-term care facility and who agree to case management. Our programs focus on improving our members' health status and quality of life, access to community resources, and reduction of unnecessary costs for CMS, our members and the plan. Our physician-led interdisciplinary team includes health outreach specialists, nurse case managers, social and behavioral health specialists, and clinical pharmacists.

Reasons for referral include, but are not limited to:

- Medical concerns regarding acute and or chronic disease process
- Behavioral health issue
- Social or financial issues
- Hospitalization issue
- Existing service issue
- Compliance issue (non-adherent with medications or with physician treatment plan)

To make a referral, simply call customer service and explain your needs. The customer service representative will secure relevant/needed information, forward to the Case Management Department, where the request will be triaged and assigned. The receiving party will communicate back to the requestor of services as needed.

Emergency Care

Blue Advantage advises members to go to the nearest hospital emergency room if they believe their health is in serious danger. A medical emergency may include severe pain, a serious injury or illness or a medical condition that is rapidly getting worse.

The Blue Advantage Medical Management department MUST be notified of a hospital admission within 24 hours or by the end of the next business day. If an admission through the emergency room is made by a provider other than the PCP, the PCP should be notified within 24 hours or the next business day following the admission.

Ambulance service for transportation to the hospital is a covered benefit for members in emergencies only. In such an emergency, 911 or another local emergency number should be called.

Out-of-area Care/Urgent Authorizations

Urgent care refers to care delivered when members need medical attention right away for an unforeseen illness or injury, and it is not reasonable, given the situation, for members to get medical care from their PCPs or other plan providers. Members (or their authorized representatives) are instructed to contact their PCPs as soon as possible. When urgent care is needed in the service area, members should contact their PCPs to direct their care. Notification is required for all urgent out-of-area hospital admissions. You or your patient (or your patient's representative) may satisfy this obligation by contacting a representative of the Medical Management department.

Non-participating Hospitalization

Whenever Blue Advantage is advised that a member has been hospitalized on an emergency basis in a non-participating facility, we will notify the member's PCP. If the member calls the PCP, then the PCP is required to notify Blue Advantage within one business day. The patient may be transferred to a Blue Advantage participating facility when the patient's condition has stabilized. These services require authorization by the Medical Management department.

Dialysis Patients

For those providers who initiate hemodialysis for ESRD patients, CMS requires dialysis providers to enter the CMS-2728 Form into the CMS established and governed system, CROWNWeb. Once the information is entered into the system, the provider should print out the form, sign it, have the member sign it and mail it to the Social Security Administration. The website for CROWNWeb is www.projectcrownweb.org.

Institutionalized Patients

When a member is in need of long-term custodial care, the member and family can choose any facility within our service area to reside. Please note that the member is going to that facility in a private pay capacity, as neither Blue Advantage nor Traditional Medicare cover the cost of custodial care. Blue Advantage needs to be

informed of this action either by the member, family member or the PCP. The individual can remain a member of Blue Advantage; however, the member must continue to abide by plan rules for any care required while living in the facility. For example, non-custodial care must be directed by a network PCP. Blue Advantage providers must be utilized to receive most covered services.

The PCP has various options to manage a custodial patient, which include:

1. If practical, the patient can continue to be seen in the PCP's office.
2. The PCP can continue to see and treat the patient in the facility.
3. The Medical Director of the facility may oversee the patient's care on behalf of the PCP. Good communication needs to be established between the PCP and the Medical Director for the continuation of coordinated care.

Pharmacy Management

Pharmacy Network

Blue Advantage provides coverage for prescription medications and members may have their prescriptions filled through a wide network of pharmacies, including mail order. Please refer your Blue Advantage patients to their provider/pharmacy directory for a comprehensive list of participating pharmacies. To view the provider/pharmacy directory, go to www.BCBSLA.com/ilinkblue >Blue Advantage under "Other Sites" >Provider & Pharmacy Search.

Our pharmacy network includes pharmacies that offer preferrd cost-sharing. Members who fill their prescriptions at a preferred pharmacy (including mail-order) may pay less for their medications. Preferred pharmacies will be identified in the provider/pharmacy directory.

Medicare Part D Formulary

Blue Advantage utilizes a formulary (list of covered drugs) for Medicare Part D coverage. For a specific list of covered drugs, please refer to the Blue Advantage formulary, which is available in print and also on our website. The formulary is updated each month and posted to the Blue Advantage Provider Portal.

The Medicare Modernization Act of 1996 specifically prohibits certain medications from being covered under Medicare Part D; therefore, the following types of drugs are specifically excluded from coverage for Blue Advantage members:

- Drugs used for anorexia, weight loss or weight gain (except when used to treat AIDS wasting and cachexia due to a chronic disease)
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for the symptomatic relief of cough and colds
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Non-prescription (over-the-counter) drugs
- Agents when used for the treatment of sexual or erectile dysfunction (ED)

Blue Advantage has made arrangements with its pharmacy benefit manager, Express Scripts, Inc., to perform certain Part D functions such as Coverage Determinations and Appeals. Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Blue Advantage published formulary. For information on how to submit a coverage determination or formulary exception request, please refer to the section below called **Part D and Part B Drugs Requiring Prior Authorization**.

Medicare Part D Benefit

Drug Category (Tier)
Tier 1 – Preferred Generics
Tier 2 – Generics
Tier 3 – Preferred Brand
Tier 4 – Non-preferred Drug
Tier 5 – Specialty

The Blue Advantage Part D formulary is organized into five drug tiers.

Members pay a copayment for drugs in Tiers 1 through 4, and a coinsurance for drugs in Tier 5. In general, the lower the drug tier, the lower the member's cost share.

There are three coverage phases under the Medicare Part D benefit: 1) the Initial Coverage Phase (ICP); 2) the Coverage Gap Phase (commonly referred to as the "donut hole"); and 3) Catastrophic Coverage Phase. During the ICP, a member pays part of the cost of a covered Part D drug, such as a deductible, if applicable, and a copayment or coinsurance and Blue Advantage pays the remainder. The member remains in the ICP until the total drug costs reach a predetermined dollar amount established by CMS, also known as the Initial Coverage Limit (ICL), which is $4,020 for the 2020 plan year.

Once members reach the $4,020 limit, they move to the Coverage Gap Phase, also known as the "donut hole." Members receive a discount off the cost of some brand and generic drugs while in the coverage gap; the amount of the discount is predetermined by CMS each year. For 2020, members will continue to pay their regular copay for Tier 1 and Tier 2 generics. Members will pay 25% of the cost for other covered generic drugs and 25% of the cost for covered brand-name drugs.

Members remain in the Coverage Gap Phase until they have paid an Out-Of-Pocket Amount equal to a pre-determined dollar amount as established annually by CMS. The amount for 2020 is $6,350. After reaching the out-of-pocket amount, members move into the Catastrophic Coverage Phase. In the Catastrophic Coverage Phase, members are responsible for paying a small copayment or coinsurance, as established annually by CMS, for covered Part D drugs and Blue Advantage pays the remainder of the drug cost.

90-Day Supply: Member Cost-savings and Improved Adherence

When treating chronic conditions, patients that receive prescriptions for an extended (90-day) supply often have better medication adherence. Studies demonstrate increased medication adherence leads to better outcomes and lower total cost of care. To assist with this, we allow most medications to be filled as a 90-day supply at retail pharmacies and via mail-order. For additional cost-savings, patients can get a 90-day supply of Tier 1 and Tier 2 drugs for a $0 copay when filled at a preferred retail pharmacy or by mail. Please note: you **must** write for a 90-day supply—pharmacies may not be able to convert a traditional 30-day prescription. More information about 90-day supply and mail-order can be found on the Pharmacy page of the member portal.

Medicare-covered Drugs (also called Medicare Part B Drugs)

Drugs covered under original Medicare are also covered for Blue Advantage members. This includes substances that are naturally present in the body, such as blood clotting factors. There is no benefit limit on

these drugs, and their cost does not count toward the member's outpatient prescription drug benefit. There is no formulary for Part B covered drugs, but certain Part B drugs require prior authorization from Blue Advantage. For more information, please see "Part D and Part B Drugs Requiring Prior Authorization" below. For the list of Part B drugs requiring prior authorization and the prior authorization criteria, please see the Blue Advantage Provider Portal >Pharmacy Benefit Resources.

The following drugs are Medicare-covered drugs:

- Drugs that usually are not self-administered by the patient and are injected while receiving physician services
- Drugs used with durable medical equipment (such as nebulizers) that were authorized by Blue Advantage
- Clotting factors self-administered by a member that has hemophilia
- Immunosuppressive drugs, if the member had an organ transplant that was covered by Medicare
- Injectable osteoporosis drugs, if the member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and the member cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs, once only available in an injectable form, that were covered by Medicare
- Certain oral anti-nausea drugs used as a full replacement for intravenous treatment and administered within 48 hours of cancer treatment
- Insulin when administered via insulin pump
- Erythropoietin if the member has end-stage renal disease, receives home/outpatient dialysis and needs this drug to treat anemia
- Select immunizations, including flu and pneumonia, and Hepatitis B for individuals at high or intermediate risk

Part D and Part B Drugs Requiring Prior Authorization

Requests for coverage of drugs are routed differently depending on who is furnishing and billing for the drug (pharmacy vs. medical). Please review the information and educate office staff as needed to ensure that coverage requests are submitted through the proper channels. This helps prevent situations where a drug was authorized through one channel but billed through another channel and subsequently denied for no authorization in place. Drugs on the formulary that could process under Part D or Part B at a pharmacy are labeled with abbreviation "B/D PA." The coverage criteria for Part D and Part B drugs that require prior authorization can be found on the Blue Advantage Provider Portal.

Part D Drugs Furnished and Billed Through Pharmacy

Part D Prescription Drug Coverage Form

You have several methods to choose from when requesting a coverage determination for your Blue Advantage patient. You can reach us by phone, fax, mail or online. Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Blue Advantage published formulary. These are all examples of coverage determinations. To request a coverage determination for a Part D drug, you can contact Express Scripts, Inc. The contact information is in the Plan Information Contact List located in the front of this manual. You can also complete the Part D Prescription Drug Coverage Determination Request Form and return it to the contact information listed in the Plan Information Contact List located in the front of this manual. The form is available for download from the Blue Advantage Provider Portal under the Forms link or you can call the plan and request that we fax the form to your office. You can also access an electronic version of the form from the Blue Advantage Provider Portal.

To submit an electronic request for a review determination for a Part D drug, online tools are available to provide real-time responses. There are three options for prescribers based on their practice preferences. The first two options are web-based portals; see the URL links below. Prescribers will simply need internet access to be able to submit requests electronically. You must first register as a user on each portal. Once registered with your selected vendor, covermymeds or expressPAth, you will see the step-by-step process for submitting coverage determination requests. The required information you enter when submitting an electronic request is identical to what you would need to provide via phone or fax.

www.covermymeds.com

www.express-path.com

Electronic Prior Authorization (ePA) is available within the practice EMR software today (if ePA capabilities are not available in your practice software, you may request the capability from your software vendor). In this application, the prescriber can be alerted that a prior authorization is required when submitting an electronic prescription. The prescriber is able to initiate a coverage determination request from within the practice software, and does not need to move to one of the web-based portals mentioned above.

Some drugs require a coverage determination for the purpose of determining whether they should be covered under Part D or Part B for the specific situation, based on Medicare rules. You may be asked to provide information regarding diagnosis or other pertinent information in order to facilitate the determination.

To access the Part D Prescription Drug Coverage Determination Form, please refer to the Blue Advantage Provider portal.

Part B Drugs Furnished and Billed Through Medical
Part B Drug Prior Authorization Request Form

Certain Part B drugs billed through the medical benefit are subject to prior authorization. Prior authorization requests may be made by calling Blue Advantage Medical Management. The contact information is in the Plan Information Contact List located in the front of this manual. Requests may also be made by completing the Part B Drug Prior Authorization Request Form or one of the drug-specific forms can be found on the Blue Advantage Provider Portal. Completed forms should be faxed or mailed to Blue Advantage Medical Management at the fax number/address located at the top of the form.

Expedited Timeframes for Prior Authorization Requests

Expedited prior authorization requests should be reserved for cases when you are able to attest that the patient's health or life could be in jeopardy if the standard timeframe is applied. Please note that for expedited requests for Part D drugs, the plan must make the determination and notify the member within 24 hours. If expedited requests are submitted late on a Friday or the day before a holiday, the plan has limited time to contact you for information, and you have limited time to respond before your office closes and the 24 hour expedited timeframe expires. We will make every effort to contact the office, but by requesting the standard timeframe (72 hours) whenever medically appropriate, you give yourself and the plan sufficient time to obtain information needed to make the determination. CMS recently clarified the expectation that plans reach out to the on-call physician for expedited Part D coverage requests on weekends or holidays, so the plan will make such outreaches. Please discuss this with your office staff who complete and fax the forms.

Starting in 2020, Part B drugs billed through medical that have a prior authorization will now share the same timeframes for determination as required for Part D drugs – 72 hours for standard requests or 24 hours for an expedited review.

With all requests, particularly expedited requests, please make every effort to provide as much information as possible in order for the plan to make the determination. It is helpful to review the prior authorization criteria on the provider portal and submit all of the required information with the request. For some Part B drugs billed through medical, there are drug-specific prior authorization request forms which can be found on the Blue Advantage Provider Portal and will show you the specific information we need for that drug. Finally, if the plan reaches out to your office to request additional information, please respond promptly.

Opioid Utilization Review and Controls

CMS mandates that Part D sponsors must employ effective concurrent and retrospective drug utilization review (DUR) programs to address overutilization of medications; specifically to address opioid overutilization among its Part D enrollees. CMS recognizes "overutilization" as filling of multiple prescriptions written by different prescribers at different pharmacies for the same or therapeutically equivalent drugs in excess of all medically-accepted norms of dosing. In 2019, we began limiting initial opioid prescriptions to a seven-day supply when used for the treatment of acute pain. CMS also expanded the Overutilization Monitoring System

(OMS) and now allows Blue Advantage to "lock-in" patients we identify as a high-risk opioid user to a single provider or pharmacy. There are specific requirements that we must follow if this were to be implemented for one of your patients and we would work with you before those actions are taken.

These controls were put in place, per CMS guidance, to aid national efforts in tackling opioid abuse and misuse. For more information about the Blue Advantage opioid overutilization program, please refer to the Blue Advantage Provider Portal and click the "2020 Pharmacy Benefit Resources" link, under the "2020 Guides and Resources" heading.

If your office receives an Opioid Overutilization Monitoing Program fax from Blue Advantage, please respond promptly to facilitate the case management process.

Part D Payment for Drugs for Beneficiaries Enrolled in Hospice

CMS requires that Part D sponsors place beneficiary-level prior authorization requirements on four categories of drugs for patients enrolled in hospice, to prevent hospice-related drugs from paying under Part D. These categories include analgesics, antiemetics, laxatives and anxiolytics. For members enrolled in hospice, these drugs will not pay under Part D, unless the hospice provider attests that the drug is unrelated to the terminal illness and related conditions. If the drug is deemed to be unrelated to the terminal illness and related conditions, an authorization will be placed into the pharmacy claims system to allow the drug to pay under Part D. Otherwise members will be directed to obtain the medicine from the hospice provider.

Payment for Drugs for Beneficiaries with ESRD

CMS requires that Part D sponsors use point-of-sale edits to prevent ESRD-related drugs from paying under Part D. If a member has an ESRD flag, drugs that are considered by CMS to be always related to ESRD will not pay under Part D. Members will be directed to obtain the medicine from their dialysis facility.

Medication Therapy Management Program (MTMP)

The Blue Advantage MTMP is a patient-centric program aimed at improving medication use and adherence, reducing the risk of adverse events and helping patients who have difficulty paying for medicines find lower-cost therapeutically appropriate medications or resources to help pay for medications. Certain members who have chronic diseases, take multiple medications and have high cost for medicines are enrolled in the program. We provide telephonic comprehensive medication reviews (CMR) as well as targeted medication reviews (TMR) to help identify and resolve medication related problems. Our program complements the care patients receive from their physicians, and does not interfere with the doctor-patient relationship. We have found that our members are very appreciative of the program. For more information about the Blue Advantage MTMP, please refer to the Blue Advantage Provider Portal and click on the "Pharmacy Benefit Resources" link, under the "2020 Guides and Resources" heading.

Online Prescription Drug Coverage Determination for All Providers

A prescribing provider can submit a prescription drug coverage determination request online through the Blue Advantage Provider Portal. There are a variety of reasons in which a coverage determination may be needed. For example, a request for coverage of a non-formulary drug, tier exceptions, Step Therapy, etc. This request goes directly to Blue Advantage Medical Management. A provider can also submit a request for a redetermination (appeal) for a Part D prescription drug online. See the Pharmacy Management section of this manual for additional information regarding prior authorization for Part D and Part B covered drugs.

Claims and Billing Guidelines

Fiscal Intermediary Letter Requirement

As a Medicare Advantage Plan, our Blue Advantage network follows CMS billing guidelines. To ensure accurate claim processing, Blue Advantage must have a copy of your fiscal intermediary letter on file for the following provider types:

- Critical Access Hospitals (CAH)
- Rural Health Clinics (RHC)
- Federally Qualified Health Clinics

If the fiscal intermediary letter is not received, Blue Advantage cannot correctly calculate the payment owed to the provider. Blue Advantage providers, paid on a reasonable cost basis, should include the member ID number and date of service on the fiscal intermediary letter. Claims will remain pending until the fiscal intermediary letter is received or the provider will be paid the standard Blue Advantage rate.

Please email your fiscal intermediary letter to network.development@bcbsla.com or fax it to (225) 297-2750.

Medicare Advantage PPO Network Sharing

All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as the member sees a contracted MA PPO provider. In Louisiana, we share our Blue Advantage (PPO) network with MA PPO members from other states.

- If you are a contracted Blue Advantage (PPO) provider you should provide the same access to care for Blue MA PPO members as you do for Blue Advantage (PPO) members. Services for Blue MA PPO members will be reimbursed in accordance with your Blue Advantage (PPO) allowable charges. The Blue MA PPO member's in-network benefits will apply.

  If your practice is closed to new Blue Advantage (PPO) members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as to Blue Advantage (PPO) members.
- If you are not a participating Blue Advantage (PPO) provider but do accept Medicare and you see Blue MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergent care, you will be reimbursed at the member's in-network benefit level.

Blue MA PPO members are recognizable by the "MA" suitcase on the member ID card. Blue MA PPO members have been asked not to show their standard Medicare ID card when receiving services. Instead, Blue MA PPO members should provide their Blue Cross/Blue Shield member ID card.

Use iLinkBlue (www.BCBSLA.com/ilinkblue) to verify eligibility and benefits or call the number on the member ID card. Claims for services rendered in Louisiana, should be filed directly to Blue Cross and Blue Shield of Louisiana. Do not bill Medicare directly for any services rendered to a Blue MA PPO member.

Claims and Encounter Data Submission

Claims and encounter data (for capitated and non-capitated providers) must be submitted using standard Medicare guidelines. Blue Advantage accepts CMS-1500 or UB-04s and electronically submitted claims transmitted through Change Healthcare.

Contracted providers should seek electronic claims solutions as indicated in their Blue Advantage contract. Providers who bill on paper should follow standard CMS claims submission requirements including submission of the Blue Advantage Member ID with leading zeros and NPI in the appropriate claim form field.

The provider is responsible for ensuring accurate and complete data for submission. The provider is also responsible for any request made on his or her behalf by the staff personnel. Claims are not accepted via fax. When filing claims for secondary coverage please, be sure to include the Explanation of Benefits from the primary insurer or the claim will be denied. Blue Advantage is able to accept COB (coordination of benefits) claims filed electronically, as long as the applicable fields are completed.

Blue Advantage processes all clean claims within the 30-day CMS required standards. Status checks/claims inquiries can be performed via our Provider Portal. Since Blue Advantage permits submission of the claims for up to 12 months from the date of service, unless indicated otherwise in your specific provider agreement, it is not necessary to establish a short auto claims submission refiling cycle.

Not all claims for Blue Advantage members are filed directly to the Blue Advantage administration office. The following should be filed directly to the vendor:

- Preventive and routine dental services are filed to United Concordia
- Routine eye exams and eyewear, as well as post cataract surgery eyewear, are filed to Davis Vision

If you are a "dual eye provider," i.e., you are contracted with both Davis Vision (as a routine eye provider) and Blue Advantage (as a specialty provider, ophthalmologist or optometrist), you need to bill the appropriate party based on the services provided.

Contact information for the above vendors is located in the Plan Information Contact List in the front of this manual.

Second Opinions

Blue Advantage members have the right to receive a second opinion should they desire to do so. If the second opinion fails to confirm the primary recommendation for a treatment plan, or if the member so desires, a third opinion, provided by a third provider can be sought. If there is no qualified provider to perform the second or third opinion consultation within the Blue Advantage provider network, the PCP will need to contact the Medical Management department for assistance and approval to go outside the network for the consultation.

Electronic Claims

Electronic claims require the same information as paper. However, electronic submission of claims dramatically improves the exchange of information and the acceptance rate of claims, while reducing opportunities for error. This process also decreases the turnaround time for claims payment. These factors combine to reduce a provider's overall administrative costs. Blue Advantage accepts initial claims submissions electronically through Change Healthcare (Blue Advantage payor #84555).

Claims filed electronically are NOT considered "received" unless they have passed our system edits and have been accepted into our system. For every claim filed electronically, the provider should receive two reports back:

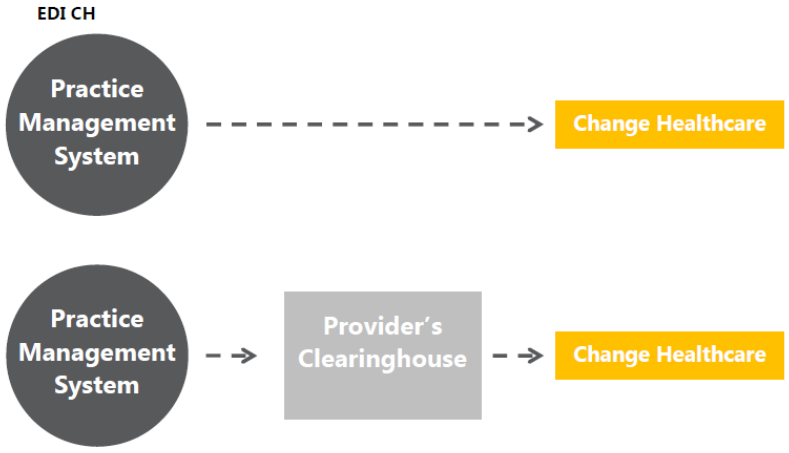
1. A report that the clearinghouse accepted the claim
2. A file stating the action taken by Blue Advantage (Second Level Acceptance Report)

If you are not receiving both reports, please check with your clearinghouse. It is important to review rejection reports. Working your electronic rejection reports prior to looking up the information via the Blue Advantage Provider Portal for claim status increases the timeliness of the process.

To confirm we are receiving your claims and processing them electronically, the sixth position of the claim number that appears on your remittance notice will be an "E." If the sixth position is a zero or "I," we are receiving paper claims. If your EDI submissions are being rejected, and you are not receiving clear direction as to the cause, contact Blue Advantage customer service. Explain that you are experiencing an ongoing EDI submission issue, and you will be directed to the appropriate staff to help work on a resolution.

Electronic Claims Submission

All electronic claims (professional and facility) must be received via Change Healthcare. Blue Advantage is unable to receive claims filed directly from any other source.



Blue Advantage does offer Electronic Remittance Advice availability. Please see specific details under **Electronic Payment and Remittance Notice** further in this manual.

Proper Submission of Provider IDs

Since Blue Advantage is a Medicare Advantage plan, we follow Medicare billing guidelines. To ensure payment is issued to the correct provider of service, we suggest the following claims submission tips:

- All "physician services" require identification of the rendering provider's NPI. If you have indicated payment should be issued to a group, this will be done via set up processes within our system.
- All extenders, i.e., nurse practitioners, physician assistants, must be identified since under Medicare guidelines a slightly reduced fee schedule applies.

Provider IDs via paper claims:

CMS-1500

Block 25: the Tax ID must be indicated

Block 31: the rendering provider's name must be indicated

Block 24J: the rendering provider's NPI must be indicated

Block 32: the location where the services were provided

Block 32A: the NPI of the location where the services were provided

Block 33: billing provider name such as the group practice, company name, etc.

Block 33A: billing provider's NPI

UB-04

Block 1: provider name, address and telephone number

Block 2: pay to name, address and telephone number Box 5 the Tax ID

Block 56: NPI

Blue Advantage provides a "Member look up file" to the clearinghouses. The Blue Advantage member ID and the first five alpha characters of the individual's last name must match in order for the claim to bypass that edit. If you receive individual member rejects, confirm the spelling and spacing in the last name submitted on your file.

Explanation of Benefits

Blue Advantage issues two types of explanation of benefits (EOB) to members:

1. A medical EOB is generated monthly and reflects all claims processed the prior month with the exception of services which are rejected back to the provider of service. Rejected claims are claims which require additional or corrected information in order to consider the service for benefits. (An example of rejects are claims that require a corrected procedure code or a primary carrier's EOB).
2. A Part D prescription drug EOB is generated monthly and reflects both the prior month's Part D claims activity as well as the member's year-to-date total drug spend and true out-of-pocket costs, which determines the phase of the Part D benefit the member is currently in.

Members can also obtain real-time information online via our website once they establish a secure login and password. EOBs are only issued if the member has had claims activity the prior month.

Coordination of Benefits (COB)

When Blue Advantage is the primary carrier, we will compensate participating providers in accordance with the terms of their Blue Advantage agreements. If the payment does not cover all incurred charges, the provider may submit a claim to a secondary carrier. However, providers may not seek additional compensation for charges from members other than copayments and coinsurance.

When Blue Advantage is the secondary carrier, the provider should first seek payment from the member's primary carrier. For Blue Advantage to pay the member's copayment or coinsurance, up to the amount we would have paid had we been the primary carrier, the provider must send us a copy of the explanation of benefits from the primary carrier.

Blue Advantage receives COB information based on CMS records. Claims are adjudicated based on this information. Members are asked to validate the information and notify us immediately if incorrect. Blue Advantage will work with the proper CMS party to have the file updated, but until that is completed, we may continue paying claims as secondary. If you are aware of an issue with the member's records, do not balance bill the member until the issue is resolved. Members eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and B cost sharing when the state is responsible for paying such amounts. Physician will be informed of Medicare and Medicaid benefits and rules for members eligible for Medicare and Medicaid. Physician may not impose cost-sharing that exceeds the amount of the cost share that would be permitted with respect to the individual under Title XIX of the Social Security Act if the individual were not enrolled in such a plan. Physician must (a) accept Blue Advantage payment as payment in full or (b) bill the appropriate state source (42 C.F.R. § 422.504(g)(1)(iii)).

Whether Blue Advantage is the primary or secondary payor, all requirements for prior authorization must be met prior to the delivery of a service or item.

Subsequent Claim Submissions:

Timely Filing Requirements

- Both contracted and non-contracted providers have 12 months from the date of service to file an initial claim unless the individual provider agreement states otherwise.
- Both contracted and non-contracted providers have 12 months from the date the claim was processed (remit date) to resubmit or correct the claim, this again can vary depending upon individual agreement language.
    - Providers should follow the CMS filing guidelines for corrected claims. Refer to the corrected claim information further in this section.
- A non-contracted provider has 60 days from the date the claim was processed (remit date) to appeal a claim determination.

Blue Advantage permits claims submission up to 12 months from the date of service. In exchange, the Blue Advantage plan policy requires providers resubmit any standard billing denials, (i.e., wrong or incomplete member ID, invalid procedure code modifier combination, etc.) as a new claim either on paper or electronically, whichever applies to your regular billing method. This is the most expeditious way to receive payment. The resubmitted claim will not be denied as a duplicate claim, as long as no payment was issued on the service line in question. If the claim was denied for no referral or prior authorization, the provider needs to confirm via the portal or by calling Medical Management that an authorization is on file prior to resubmitting the claim.

If a provider is disputing a timely filing denial of a claim, and the claim is filed:

Electronically: The only proof Blue Advantage will accept as timely filing is the second level acceptance report from the clearinghouse that the claim was accepted by Blue Advantage.

Paper: The provider must submit supporting documentation from the provider's practice management system. This must include the applicable field descriptions since the documentation is specific to your system OR a UB-04, CMS-1500 with the original date billed AND documentation to support the claim being submitted within 12 months from the date of service, AND follow-up done at a minimum of every 60 days. If there is no documentation supporting the follow-up activity, i.e., filed second submission MM/DD/YYYY or contacted plan and spoke with_____, on MM/DD/YYYY, the timely filing denial will stand. We must have the documentation for CMS audits.

Claim Resubmission

A claim is processed by Blue Advantage and the provider resubmits the claim generally due to a denial that occurs on either a claim line or the entire claim (i.e., no referral on file). If an amount was paid on the claim line in question, the provider should not use the claim resubmission process. See additional options below. However, if no payment was issued on the claim line in question, the claim can be resubmitted on paper or electronically, not faxed, unless an approved exception is made due to special circumstances. No provider explanation is necessary on the resubmitted claim. The claim will be treated as an initial claim for processing purposes.

Corrected Claim

A corrected claim, per the standard contract language, is a claim in which the provider needs to add, remove or change a previously paid claim line. This must be within the time frames outlined in the individual provider contract but is often a very short span of time (30 to 90 days from the original claim submission). Examples of removing or adding a previously paid claim line would be: Remove charges billed for a service that was ultimately not provided or add charges for a service that was provided and not billed. Examples of changing a previously paid claim line include changing incorrect dates or service or correcting an incorrect procedure code. All requests must be submitted as corrected claims. All corrected claims must be clearly indicated as a correction as follows:

CMS-1500 Claim Forms (professional):

- EDI/1500/Professional claim forms submitted as "Corrected Claims" can be submitted electronically.
- In Loop 2300 ~ CLM05-03 must contain a "7," REF01 must contain an "F8," and REF02 must contain the Original Reference Claim Number.
- CMS-1500 paper claim forms submitted as "corrected claims" can also be submitted on paper. The paper 1500 claim must indicate a frequency of 7 in Block 22 (Resubmission Code) and the Original Reference Claim Number in Block 22 (Original Ref. No.).

- The claim form should reflect a clear indication as to what has been changed. All previous unchanged line items must be submitted on the corrected claim along with the line items that are being corrected.

UB-04 Claims Forms (facility):

- EDI/UB/Facility claim forms submitted as "Corrected Claims" can be submitted electronically.
- The Type of Bill (TOB) must indicate a frequency 7 and the claim submitted must indicate in Loop 2300 REF01 an "F8" and REF02 must contain the Original Reference Claim Number.
- UB-04 paper claim forms submitted as "corrected claims" can also be submitted on paper.
- The paper claim must indicate a Frequency of 7 in Block 4, the Original Reference Claim Number in Block 64 and a reason for the correction in Block 80.

Re-openings: This is generally used by the plan if they discover an issue and proactively reprocess claims based on that finding. For example, we find we have incorrectly denied a certain type of claim for a particular provider and run an extract to identify past denied claims and adjust them in an effort to send out the correct payment.

If a denial occurred as the result of a **Blue Advantage error**, the provider is permitted to contact customer service and if possible, the necessary action to correct the situation will occur without additional action from the provider.

Any questionable requests will be returned with a cover letter that can be used to notate the change and return the claim, this includes if you are adding additional billed charges.

Provider Pay Disputes

Blue Advantage has made payment on a claim or line but the provider disagrees with the amount that has been paid. Again, the time frame is indicated in the provider's individual contract, but in general, is permitted if brought to our attention within 12 months from when the initial claim was paid. In no case may contracted providers seek additional compensation from members other than copayments, coinsurance and payment for non-covered services.

Provider pay disputes should be submitted in writing. Your request should outline the basis for the dispute and should include documents supporting your position. Please send your written claims dispute requests with all supporting documentation to Blue Advantage Correspondence. The address is located in the front of this manual.

Blue Advantage will communicate the decision either verbally or in writing if we feel the correct amount was previously paid. If we correct the payment it will appear on a remittance advice to the requesting provider. The review by Blue Advantage and its determination is final.

Disputes other than claims or authorizations should be submitted in writing to Blue Advantage Correspondence.

Formal Dispute Resolution & Arbitration Process

(does not include provider pay disputes)

Dispute Resolution:

Blue Advantage has established a formal dispute resolution process. To initiate the formal dispute resolution process, providers should send a written notice with a brief description of their dispute to:

mail: Blue Advantage Provider Dispute
P.O. Box 7003
Troy, MO 48007

Within 60 calendar days of our receipt of the provider's notice, Blue Advantage and the provider will assign appropriate staff members who are to arrange to discuss and seek resolution of the dispute, consistent with the terms of the provider's agreement with Blue Advantage. Any and all dispute resolution procedures are to be conducted only between Blue Advantage and the provider and shall not include any Blue Advantage member, unless such involvement is necessary to the resolution of the dispute. Blue Advantage, in its sole discretion, will determine if the member's involvement is necessary to the resolution of the dispute.

If Blue Advantage and the provider are unable to reach resolution within the initial 60-day period, then management from both Blue Advantage and the provider, who were not involved in the initial discussion, will have an additional 30 days to resolve the dispute. This time period may be extended by mutual agreement between Blue Advantage and the provider. Blue Advantage and the provider, as mutually agreed, may include a mediator in such discussions. Blue Advantage and the provider shall share the costs of the mediation equally. In any event, if additional meetings are held and no resolution of the dispute is reached within 60 days from the initial meeting, Blue Advantage and the provider shall elect binding arbitration as described in the Arbitration section of this manual in order to resolve the dispute. Blue Advantage or the provider's failure to participate in the arbitration proceedings means that they have accepted the other's demands.

If resolution of the dispute occurs, Blue Advantage and the provider shall express the resolution in written form or amend the provider's agreement to include the resolution, if appropriate.

Arbitration:

Both Blue Advantage and the provider shall abide by the following procedures for the arbitration process:

The party (Blue Advantage or the provider) who is initiating the arbitration process shall send written notice to the other party setting forth the basis of the dispute and their desire to arbitrate. Blue Advantage and the provider shall share the costs of the arbitration equally. Arbitration shall be in accordance with the rules and procedures of either the American Arbitration Association or the American Health Lawyers' Association or another nationally recognized arbitration association acceptable to both Blue Advantage and the provider.

Arbitration shall be conducted in Baton Rouge, LA before a single arbitrator mutually agreed upon by both Blue Advantage and the provider.

The arbitrator shall be bound by the terms and conditions set forth in the provider's agreement and the member benefits.

The arbitrator may not award consequential, special, punitive or exemplary damages. The arbitrator may award costs, including reasonable attorney's fees, against Blue Advantage or the provider. If the decision of the arbitrator does not include such award, both Blue Advantage and the provider shall share the costs of the arbitration equally.

The decision of the arbitrator shall be final and in writing and shall be binding on both Blue Advantage and the provider and enforceable under the laws of the state of Louisiana.

The formal dispute resolution and arbitration processes described above do not supersede or replace the member appeals and grievances process for medical necessity and appropriateness, investigational, experimental or cosmetic coverage determinations as described in the Member Appeals section of this manual.

Member Appeals

A claim appeal can be filed by either a member or a non-contracted provider. Appeals must be filed within 60 days from the date of the initial organizational determination (for example, an EOB is issued or provider remit, whichever is applicable). Appeals must be submitted in writing and does not apply to contracted providers unless it involves a pre-service request. Any non-contracted provider appeals must include a CMS waiver of liability statement, which states the provider will not bill the member regardless of the outcome of the appeal. The form is sent to the provider upon receipt of any non-contracted appeal requests and is also available on our website.

mail: Blue Cross and Blue Shield of LA/HMO Louisiana, Inc.
PO Box 7003
Troy, MI 48007

fax: 1-877-553-6153
email: appeals@blueadvantage.bcbsla.com

Electronic Payment and Remittance Notice

Blue Advantage is able to generate an electronic fund transfer (EFT) for payment of services and an electronic remittance advice (ERA).

For enrollment to receive an ERA/835, please contact our ERA vendor, Change Healthcare customer service at 1-888-363-3361 or on their website at www.changehealthcare.com. If you receive the ERA (835), you **will not** receive an additional paper copy. If you have **not** signed up for the ERA (835), paper remits are generated and mailed weekly. Paper copies are not available on the Blue Advantage Provider Portal.

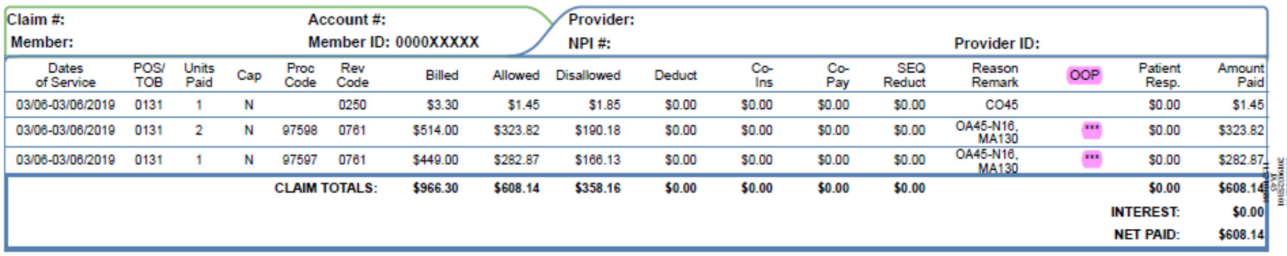
Member Copayments and Coinsurance

Copayment – It is the provider's responsibility to collect applicable copayment from members at the time of service.

Coinsurance – Blue Advantage members have the responsibility of coinsurance rather than a copayment for some services. If you provide a service to a member that has a member coinsurance, it is your responsibility to bill the member for the coinsurance amount after Blue Advantage makes payment on the claim. The remittance advice will indicate the member's liability to be billed by your office. If you know the coinsurance amount you are permitted to collect at the time of the service.

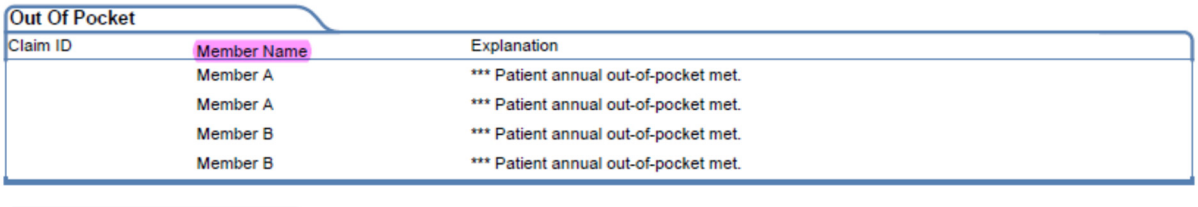
Maximum Out of Pocket (MOOP)

MOOP is the maximum a member pays out of pocket for medical (not Part D drugs) Medicare-covered services within a calendar year. When a member reaches their annual MOOP, the member will be identified on the provider remittance notice with three asterisks *** under the OOP column. Their typical cost share will no longer be applicable for the remainder of that calendar year. In addition, the member will be identified at the end of the remittance notice in a designated "Out of Pocket" box.



Claim #: Account #: Provider:
Member: Member ID: 0000XXXXX NPI #: Provider ID:

Dates of Service	POS/ TOB	Units Paid	Cap	Proc Code	Rev Code	Billed	Allowed	Disallowed	Deduct	Co-Ins	Co-Pay	SEQ Reduct	Reason Remark	OOP	Patient Resp.	Amount Paid
03/06-03/06/2019	0131	1	N		0250	$3.30	$1.45	$1.85	$0.00	$0.00	$0.00	$0.00	CO45		$0.00	$1.45
03/06-03/06/2019	0131	2	N	97598	0761	$514.00	$323.82	$190.18	$0.00	$0.00	$0.00	$0.00	OA45-N16, MA130	***	$0.00	$323.82
03/06-03/06/2019	0131	1	N	97597	0761	$449.00	$282.87	$166.13	$0.00	$0.00	$0.00	$0.00	OA45-N16, MA130	***	$0.00	$282.87
				CLAIM TOTALS:		$966.30	$608.14	$358.16	$0.00	$0.00	$0.00	$0.00			$0.00	$608.14
															INTEREST:	$0.00
															NET PAID:	$608.14



Out Of Pocket

Claim ID	Member Name	Explanation
	Member A	*** Patient annual out-of-pocket met.
	Member A	*** Patient annual out-of-pocket met.
	Member B	*** Patient annual out-of-pocket met.
	Member B	*** Patient annual out-of-pocket met.

Balance Billing

The term "balance billing" refers to billing a member above an approved amount for a payable service or billing a member for a service Blue Advantage denied. Please note that Blue Advantage members cannot be "balance billed" in most cases, whether you are a Blue Advantage network provider or not. Blue Advantage members are protected under Medicare balance billing guidelines. The Blue Advantage member is held harmless for payment beyond the Blue Advantage cost share (copayment

or coinsurance). The member's EOB (your share) and the provider's remit notice (member responsibility) indicates whether an amount is owed by the member and that is what the provider should follow when billing the member.

If Blue Advantage denies a claim for administrative reasons (invalid procedure code billed, services are not separately payable, timely filing denials, etc.), the claim should be corrected, if applicable, and rebilled for payment consideration. The member should not be billed. Please refer to our claims timely filing policy found elsewhere in this manual.

Advance Beneficiary Notice of Non-coverage (ABN)

ABNs are not applicable to members in Blue Advantage (or any MA plans). Contracted providers must do the following to hold members financially liable for non-covered services not clearly excluded in the member's EOC (Explanation of Coverage):

- Request a pre-service organization determination from Blue Advantage if they know or have reason to know that a service may not be covered by Medicare.
- If Blue Advantage denies the coverage request, it will issue an Integrated Notice of Denial (IDN) to the member and requesting provider.
- After the member is notified of denial via the IDN, prior to services being rendered, the provider may collect from the member fees for the specific services outlined in the IDN, should the member desire to receive them.

Risk Adjustment Data Validation (RADV) Audits

As part of the risk adjustment process, CMS will perform an RADV audit in order to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a RADV audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

General Billing/Reimbursement Guidelines Multiple Surgeries

Following are the payment guidelines for a facility for multiple surgical procedures performed at the same operative session, unless your specific agreement states otherwise:

Facilities

- Primary Procedure – lesser of charges or 100% of fee schedule minus copayments and deductibles, as applicable
- Secondary Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable

- Third through Fifth Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable

Following are the payment guidelines for physician/practitioner for multiple surgical procedures performed at the same operative session, unless your agreement states otherwise:

Physician/Practitioner

- Primary Procedure – lesser of charges or 100% of fee schedule minus copayments and deductibles, as applicable
- Secondary Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable
- Third through Fifth Procedure – lesser of charges or 50% of fee schedule minus copayments and deductibles, as applicable

Blue Advantage follows Medicare pricing for endoscopy procedures by reducing a multiple, same family, endoscopy claim by the base scope allowable and applying the applicable multiple surgery reductions to different family endoscopy claims.

Assistant Surgeons

Following are the payment guidelines for assistant surgeons (assuming that an assistant surgeon is warranted based upon the surgery performed):

- Physician – 16% of total amount paid to the surgeon minus copayments and deductibles, as applicable
- Phyisician Assistant, nurse practitioner and clinical nurse specialist – reimbursement is limited to 80% of the lesser of the actual charge or 85% of what a physician is paid under the Medicare Physician Fee Schedule
- Multiple surgery restrictions apply

TC vs. 26 Pricing (Technical versus Professional)

Based on standard contract language, please be aware of how the allowable is determined for procedures that contain both a technical and professional component; the professional component of diagnostic services (radiology, pathology, anesthesiology) are reimbursed at the contracted amount reflected in the provider's current contract. That means if you charge a 71020 (no modifier) so you are billing for a global procedure (both components) and your contracted rate is 115% of the Medicare fee schedule, the Blue Advantage allowable is determined by 100% of the Medicare fee schedule assigned to 71020TC + 115% of the Medicare allowable assigned to 7102026.

Subset Procedure

Procedural unbundling occurs when two or more procedures are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service. This practice leads to overpayments. When this occurs, the component procedures will be "denied" and rebundled to pay the comprehensive procedure. If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and rebundled to the comprehensive code. If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied, and the comprehensive code will be added to the claim for payment.

Not Otherwise Classified (NOC) Part B Drugs

In order for Blue Advantage to correctly reimburse NOC drugs and biologicals, providers must indicate the following in the 2400/SV101-7 data elements or Block 19 of the CMS-1500 form:

- The name of the drug
- The total dosage (plus strength of dosage, if appropriate)
- The method of administration

While only the above is required, we highly recommend that you also submit the National Drug Code (NDC) in order to help ensure the most accurate payment.

List one unit of service in the 2400/SV1-04 data element or in Block 24G of the CMS-1500 form. Do not quantity-bill NOC drugs and biologicals, even if multiple units are provided. Blue Advantage determines the proper payment of NOC drugs and biologicals by the narrative information (and NDC if provided), not the number of units billed.

Adjusted Claims, Additional Payments, Overpayments & Voluntary Refunds

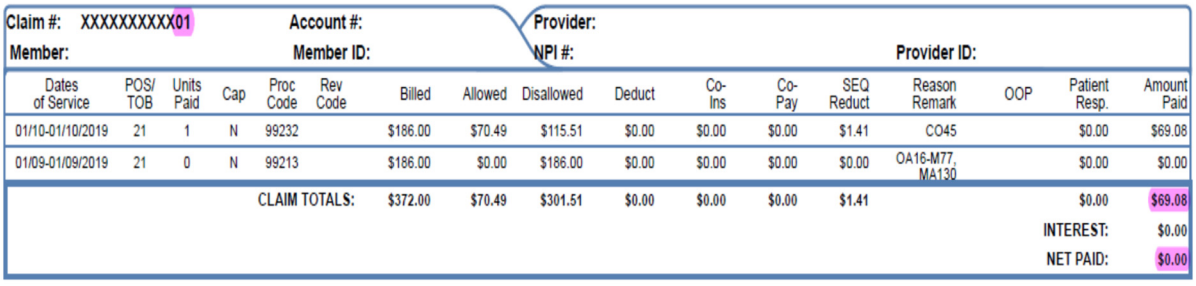
Upon discovery of an incorrectly processed claim, Blue Advantage will perform an adjustment. Adjusted claims can be identified on the Provider Remittance Notice as ending in 01, 02, 03, etc. For example, claim ID 200060E000000 would be 200060E000001. Facility claims often reflect several "adjustments" due to interim bills.

Blue Advantage claims processing system will compare the adjusted claim payment amount to the prior payment to determine whether the adjustment will result in an additional payment or overpayment. If the claim is adjusted several times, it will not consider the action of all prior adjustments, only a single prior one. So, a 02 adjustment will not consider what was paid on the 00, only what occurred under the 01 claim. As a result, if an 01 adjustment is created in error, causing an overpayment, you may be required to issue the refund, in order for us to perform a 02 adjustment and issue an additional payment. For your 1099, (tax purposes) our records reflect the correct payment amount on that particular account.

If the adjustment results in an additional payment, this will appear on the weekly provider remit. Blue Advantage issues additional payments within 30 days of discovery. If the adjustment results in an overpayment, Blue Advantage will issue an overpayment letter, providing all of the previous payment details. Only one notification is sent. In accordance with the provider's contractual agreement and non-contracted CMS regulations, Blue Advantage expects to receive a refund within 30 days of receipt of Blue Advantage notification. To ensure the refund is applied to the proper overpayment, a copy of the overpayment letter should be included with your refund. If no refund is made within 45 days of the date of the overpayment letter, the overpaid amount will be withheld from your next Blue Advantage Provider Remittance Notice. See an example remit at the end of this section. Since this often creates recordkeeping complexities (because the funds are taken from other claim payments/patient accounts) we suggest timely processing of Blue Advantage overpayment requests. If there is insufficient claim activity to recoup the overpayment, via this method, the file will be sent to a collection agency for further collection activity. Once the file is referred for collection, an additional fee is imposed by the collection agency. Blue Advantage cannot waive this fee. If you disagree with the overpayment in whole or in part, contact Blue Advantage customer service immediately to "dispute" the overpayment. During the investigation of the dispute, the overpayment will be placed on hold to ensure we do not perform a withhold until the dispute is resolved.

If you discover an overpayment via posting your Blue Advantage payments, you are obligated, via your contractual agreement and or CMS regulations, to issue a voluntary refund. Blue Advantage has created a Voluntary Refund Form (see copy in the Forms section of this manual) to ensure all information necessary to process the refund is provided. Your cooperation with timely refunds for overpayments is appreciated.

If the claim is adjusted, the last two digits will no longer end in 00. Depending on the amount of times it is adjusted, it will increment accordingly, i.e., 01, 02 etc. The Net Paid amount will either be an additional amount, difference between the initial claim that ends in 00 payment amount vs the adjusted claim that ends in 01, OR if the adjustment results in an overpayment, the "Net Paid" will be $0.00 as displayed in the following image:



Claim #: XXXXXXXXX01 Account #: Provider:

Member: Member ID: NPI #: Provider ID:

Dates of Service	POS/ TOB	Units Paid	Cap	Proc Code	Rev Code	Billed	Allowed	Disallowed	Deduct	Co-Ins	Co-Pay	SEQ Reduct	Reason Remark	OOP	Patient Resp.	Amount Paid
01/10-01/10/2019	21	1	N	99232		$186.00	$70.49	$115.51	$0.00	$0.00	$0.00	$1.41	CO45		$0.00	$69.08
01/09-01/09/2019	21	0	N	99213		$186.00	$0.00	$186.00	$0.00	$0.00	$0.00	$0.00	OA16-M77, MA130		$0.00	$0.00
				CLAIM TOTALS:		$372.00	$70.49	$301.51	$0.00	$0.00	$0.00	$1.41			$0.00	$69.08
															INTEREST:	$0.00
															NET PAID:	$0.00

If a previously requested refund is not received within the allotted time period and Blue Advantage applies a withhold/offset, the claim(s) involved in creating the overpayment will be displayed at the bottom of the remittance notice.

UNADJUSTED NET PAYABLES:	**$51,259.00**
OVERPAYMENTS RECOVERED:	**$392.00**
NET CHECK AMOUNT FOR #12345	**$50,867.00**

Overpayments

<Plan> has withheld $392.00 from your provider remit due to the following outstanding overpayment(s):

Claim Number	Patient Account Number	Member ID	Member Name	Date of Service	Overpayment Amount
12345E678910	XXXXX	000XXXXXX	Mrs. Smith	10/31/2018	$224.00
12345E678810	XXXXX	000XXXXXX	Mr. Jones	10/04/2018	$168.00

Claim #: XXXXXXXXXXX **Account #:** **Provider:**
Member: **Member ID:** **NPI #:** **Provider ID:**

Dates of Service	POS/ TOB	Units Paid	Cap	Proc Code	Rev Code	Billed	Allowed	Disallowed	Deduct	Co-Ins	Co-Pay	SEQ Reduct	Reason Remark	OOP	Patient Resp.	Amount Paid
01/31-01/31/2019	11	1	Y	9921425		$146.00	$109.04	$36.96	$0.00	$0.00	$0.00	$0.00	CO45		$0.00	$0.00
01/31-01/31/2019	11	1	N	93923		$108.00	$108.00	$0.00	$0.00	$0.00	$100.00	$0.16			$100.00	$7.84
01/31-01/31/2019	11	0	Y	2010F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	Y	3288F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	Y	3078F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	Y	3074F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	Y	1036F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	N	1160F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	Y	1159F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
01/31-01/31/2019	11	0	Y	1101F		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00			$0.00	$0.00
				CLAIM TOTALS:		$254.00	$217.04	$36.96	$0.00	$0.00	$100.00	$0.16			$100.00	$7.84
															INTEREST:	$0.00
															NET PAID:	$7.84

Quality Improvement Services

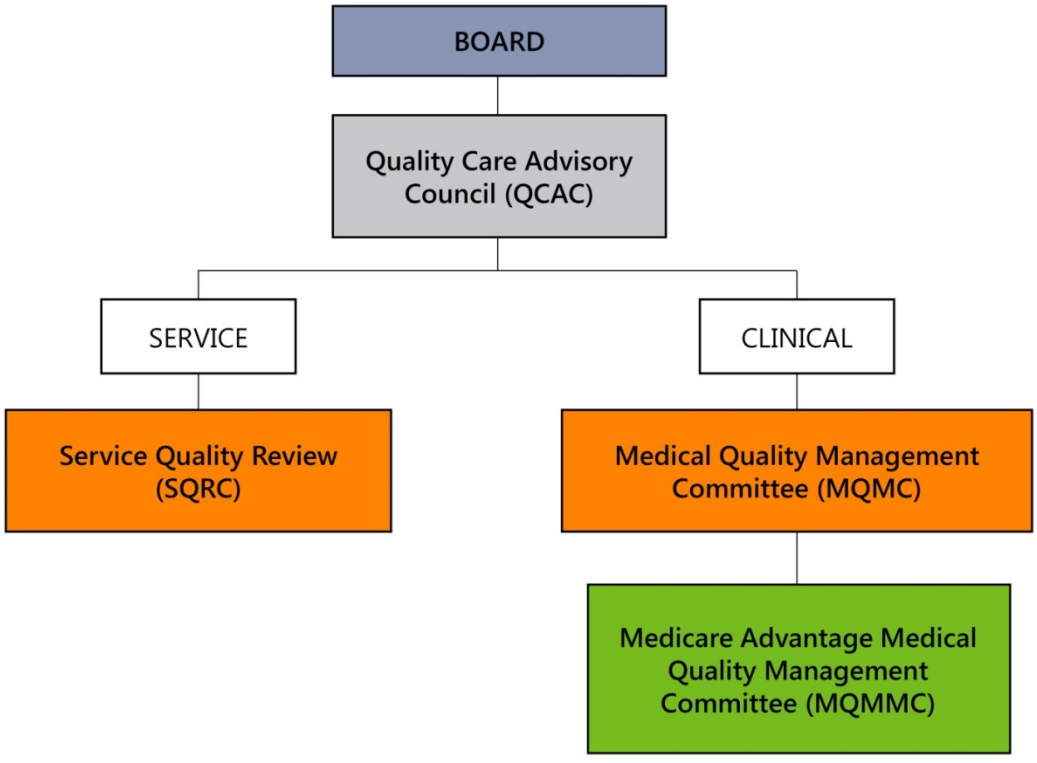
Purpose of the Quality Management Program

The Quality Management (QM) Program is a coordinated, multidisciplinary approach designed to objectively and systematically monitor and evaluate the quality and appropriateness of care delivery and to identify opportunities to improve care within the organization.

The primary purpose of the QM Program is to promote excellence in care through continuous objective assessment of important aspects of care/service, the resolution of identified problems and the implementation of process improvements. This program will encompass quality management activities that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to have beneficial effect on health outcome and patient satisfaction.

Blue Advantage's QM Committee is an interdisciplinary committee that derives its authority from the governing body and is responsible for the oversight of the QM Program. The mission of the QM Committee is to ensure that members receive quality healthcare and services. The QM Committee meets every other month and may meet more frequently, if deemed necessary.

Quality Committee Structure



Other Medicare Advantage Services

These services may not directly involve or impact our Blue Advantage products. The content in this section is for informational purposes only.

Medicare Dual Eligible Special Needs Plans

Dual Eligible SNPs (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Plan under Title XIX (Medicaid), and offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-SNPs are open to beneficiaries in all Medicaid eligibility categories including: Qualified Medicare Beneficiary without other Medicaid (QMB only), QMB+, Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only), SLMB+, Qualifying Individual (QI), other full benefit dual eligible (FBDE) and Qualified Disabled and Working Individual (QDWI).

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

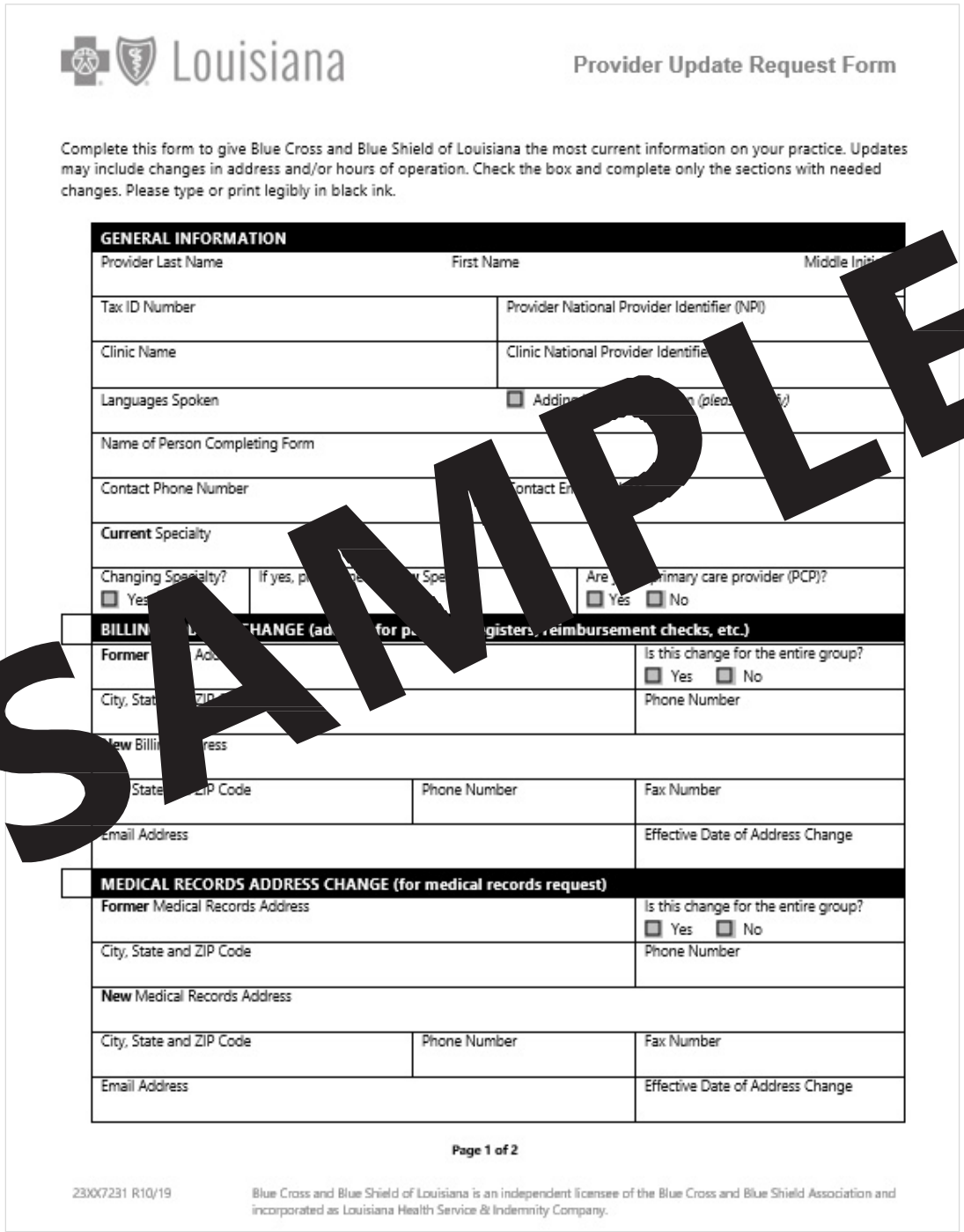
- Medicare Zero-Cost-sharing D-SNPs
- Medicare non-Zero-Cost-sharing D-SNPs

For 2020, Healthy Blue Dual Advantage (an HMO D-SNP benefit plan) is available to Blue Advantage members. Those who enroll in the Healthy Blue Dual Advantage program are issued a Healthy Blue Dual Advantage (HMO D-SNP) member ID card that should be presented at each visit in addition to presenting their Blue Advantage member ID card. More information about Healthy Blue Dual Advantage is available at https://providers.healthybluela.com.

Samples of Forms

The sample forms below are available on the Blue Advantage Provider Portal under "Forms & Resources."

Provider Demographic Change Form



Louisiana

Provider Update Request Form

Complete this form to give Blue Cross and Blue Shield of Louisiana the most current information on your practice. Updates may include changes in address and/or hours of operation. Check the box and complete only the sections with needed changes. Please type or print legibly in black ink.

GENERAL INFORMATION

Provider Last Name | First Name | Middle Initi

Tax ID Number | Provider National Provider Identifier (NPI)

Clinic Name | Clinic National Provider Identifie

Languages Spoken | ☐ Addin… (plea…)

Name of Person Completing Form

Contact Phone Number | Contact Em…

Current Specialty

Changing Specialty? ☐ Yes | If yes, p… Spe… | Are … primary care provider (PCP)? ☐ Yes ☐ No

☐ **BILLIN… CHANGE (ad… for p… gisters, reimbursement checks, etc.)**

Former Ad… | Is this change for the entire group? ☐ Yes ☐ No

City, Stat… ZIP | Phone Number

New Billi… ress

…State… ZIP Code | Phone Number | Fax Number

Email Address | Effective Date of Address Change

☐ **MEDICAL RECORDS ADDRESS CHANGE (for medical records request)**

Former Medical Records Address | Is this change for the entire group? ☐ Yes ☐ No

City, State and ZIP Code | Phone Number

New Medical Records Address

City, State and ZIP Code | Phone Number | Fax Number

Email Address | Effective Date of Address Change

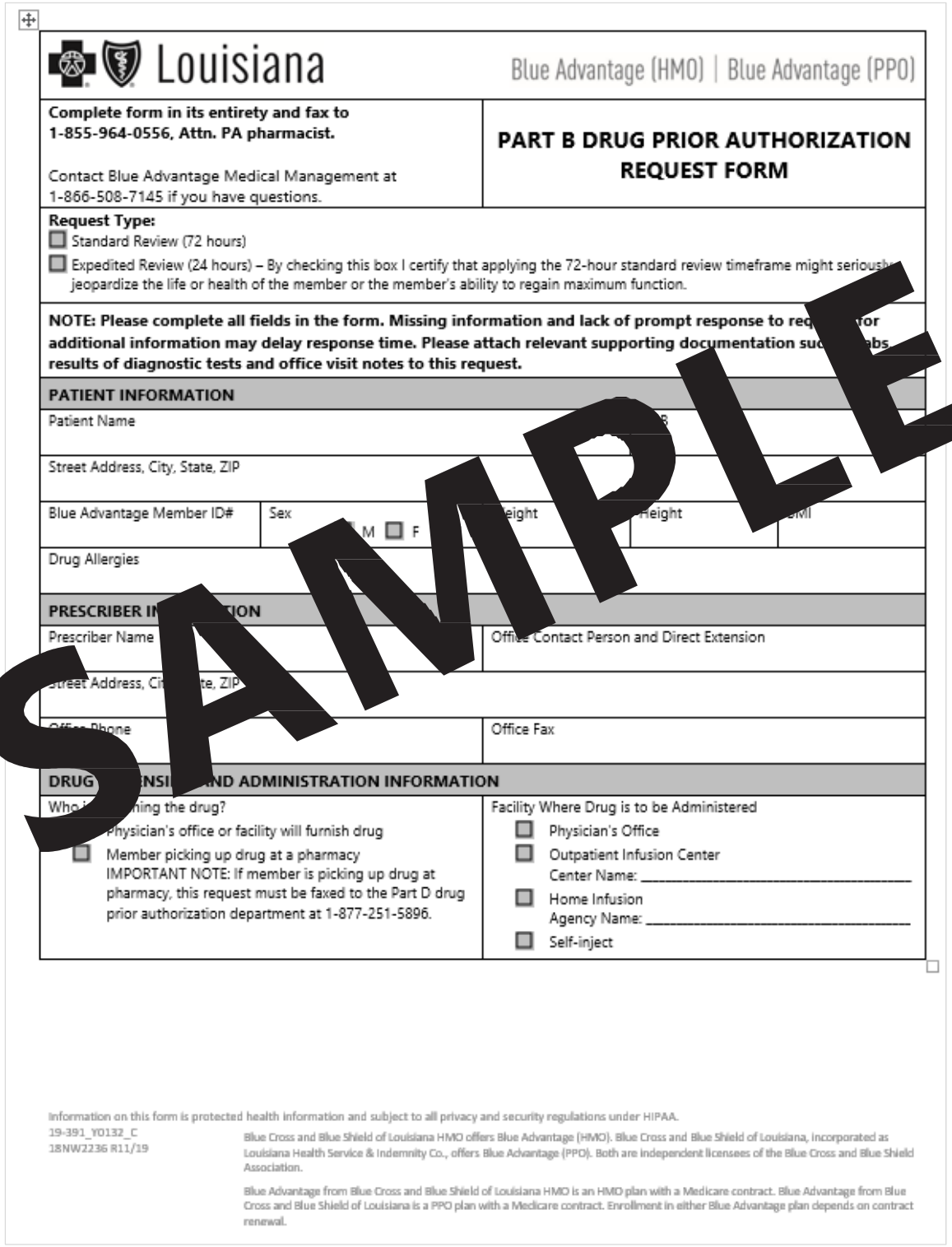
Page 1 of 2

23X07231 R10/19

Blue Cross and Blue Shield of Louisiana is an independent licensee of the Blue Cross and Blue Shield Association and incorporated as Louisiana Health Service & Indemnity Company.

SAMPLE

Request for Prior Authorization Form



Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

Complete form in its entirety and fax to 1-855-964-0556, Attn. PA pharmacist.

Contact Blue Advantage Medical Management at 1-866-508-7145 if you have questions.

PART B DRUG PRIOR AUTHORIZATION REQUEST FORM

Request Type:

☐ Standard Review (72 hours)

☐ Expedited Review (24 hours) – By checking this box I certify that applying the 72-hour standard review timeframe might seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

NOTE: Please complete all fields in the form. Missing information and lack of prompt response to req for additional information may delay response time. Please attach relevant supporting documentation suc labs, results of diagnostic tests and office visit notes to this request.

PATIENT INFORMATION

Patient Name

Street Address, City, State, ZIP

Blue Advantage Member ID# | Sex ☐ M ☐ F | eight | Height | MI

Drug Allergies

PRESCRIBER I ION

Prescriber Name | Office Contact Person and Direct Extension

Street Address, Ci te, ZIP

Office Phone | Office Fax

DRUG ENSI ND ADMINISTRATION INFORMATION

Who i ning the drug?

☐ Physician's office or facility will furnish drug

☐ Member picking up drug at a pharmacy
IMPORTANT NOTE: If member is picking up drug at pharmacy, this request must be faxed to the Part D drug prior authorization department at 1-877-251-5896.

Facility Where Drug is to be Administered

☐ Physician's Office

☐ Outpatient Infusion Center
Center Name: _____

☐ Home Infusion
Agency Name: _____

☐ Self-inject

SAMPLE

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

19-391_Y0132_C
18NW2236 R11/19

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

Integrated Denial Notice

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."	**Integrated Denial Notice**
Notice of Denial of Medical Coverage Notice of Denial of Payment	
Date:	Member Number:
Name:	

Your request was denied.

We've denied, stopped, **reduced** the payment of medical services/items listed below requested by you or your doctor

Why did we deny your request

We denied/stopped/reduced the payment for medical services/items listed above because:

You have the right to appeal our decision

You have the right to ask <<MAO>> to review our decision by asking us for an appeal:

Appeal: Ask <<MAO>> for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-866-508-7145 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We'll give you a written decision on a standard appeal within 30 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within 60 days.

Fast Appeal – We'll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with Blue Advantage

Step 1: You, your representative, or your doctor must ask us for an appeal. Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Mail, fax or deliver your appeal.

For a Standard Appeal: Mailing Address: Delivery Address:

For a Fast Appeal: **<<x>>**

What happens next?

If you ask for an appeal and we continue to deny your request for payment of a service, we'll send you a written decision and automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

Get help & more information

- 1-866-508-7145 Toll Free: TTY users call: 711
- 8:00 AM - 8:00 PM 7 days a week. You may receive a messaging service on weekends and holidays from February 15 through September 30. Please leave a message and your call will be returned the next business day.
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116

Patient Name:
Patient ID Number:
Physician:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
OMB Approval No. 0938-0692

An Important Message From Medicare About Your Rights

As A Hospital Inpatient, You Have The Right To:

- Receive Medicare covered services. This includes medically necessary hospital services and services you may need after you are discharged, if ordered by your doctor. You have a right to know about these services, who will pay for them, and where you can get them.
- Be involved in any decisions about your hospital stay, and know who will pay for it.
- Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here:

Name of QIO: KEPRO

Telephone Number of QIO:

Your Medicare Discharge Rights

Planning For Your Discharge: During your hospital stay, the hospital staff will be working with you to prepare for your safe discharge and arrange for services you may need after you leave the hospital. When you no longer need inpatient hospital care, your doctor or the hospital staff will inform you of your planned discharge date.

If you think you are being discharged too soon:

- You can talk to the hospital staff, your doctor and your managed care plan (if you belong to one) about your concerns.
- You also have the right to an appeal, that is, a review of your case by a Quality Improvement Organization (QIO). The QIO is an outside reviewer hired by Medicare to look at your case to decide whether you are ready to leave the hospital.
  - **If you want to appeal, you must contact the QIO no later than your planned discharge date and before you leave the hospital.**
  - If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
- If you do not appeal, but decide to stay in the hospital past your planned discharge date, you may have to pay for any services you receive after that date.
- Step by step instructions for calling the QIO and filing an appeal are on page 2.

To speak with someone at the hospital about this notice, call _____

Please sign and date here to show you received this notice and understand your rights.

Signature of Patient or Representative

Date/Time

Form CMS-69

Steps To Appeal Your Discharge

- **Step 1:** You must contact the QIO no later than your planned discharge date and before you leave the hospital. If you do this, you will not have to pay for the services you receive during the appeal (except for charges like copays and deductibles).
  - Here is the contact information for the QIO: Name of QIO KEPRO

Telephone Number of QIO:

  - You can file a request for an appeal any day of the week. Once you speak to someone or leave a message, your appeal has begun.
  - Ask the hospital if you need help contacting the QIO.
  - The name of this hospital is :

Hospital Name Provider ID Number

- **Step 2:** You will receive a detailed notice from the hospital or your Medicare Advantage or other Medicare managed care plan (if you belong to one) that explains the reasons they think you are ready to be discharged.
- **Step 3:** The QIO will ask for your opinion. You or your representative need to be available to speak with the QIO, if requested. You or your representative may give the QIO a written statement, but you are not required to do so.
- **Step 4:** The QIO will review your medical records and other important information about your case.
- **Step 5:** The QIO will notify you of its decision within 1 day after it receives all necessary information.
  If the QIO finds that you are not ready to be discharged, Medicare will continue to cover your hospital services.
  If the QIO finds you are ready to be discharged, Medicare will continue to cover your services until noon of the day after the QIO notifies you of its decision.

If You Miss The Deadline To Appeal, You Have Other Appeal Rights:

- You can still ask the QIO or your plan (if you belong to one) for a review of your case:
  - If you have Original Medicare: Call the QIO listed above.
  - If you belong to a Medicare Advantage Plan or other Medicare managed care plan: Call your plan.
- If you stay in the hospital, the hospital may charge you for any services you receive after your planned discharge date.

For more information, call 1-800-MEDICARE (1-800-633-4227), or TTY: 1-877-486-2048.

Additional Information:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0692. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Notice Instructions: The Important Message From Medicare

Completing The Notice

Page 1 of the Important Message from Medicare

A. Header

Hospitals must display "Department of Health & Human Services, Centers for Medicare & Medicaid Services" and the OMB number.

The following blanks must be completed by the hospital. Information inserted by hospitals in the blank spaces on the IM may be typed or legibly hand-written in 12-point font or the equivalent. Hospitals may also use a patient label that includes the following information:

Patient Name: Fill in the patient's full name.

Patient ID number: Fill in an ID number that identifies this patient. This number should not be, nor should it contain, the social security number.

Physician: Fill in the name of the patient's physician.

B. Body of the Notice

Bullet number 3 – Report any concerns you have about the quality of care you receive to the Quality Improvement Organization (QIO) listed here

Hospitals may preprint or otherwise insert the name and telephone number (including TTY) of the QIO.

To speak with someone at the hospital about this notice call: Fill in a telephone number at the hospital for the patient or representative to call with questions about the notice. Preferably, a contact name should also be included.

Patient or Representative Signature: Have the patient or representative sign the notice to indicate that he or she has received it and understands its contents.

Date/Time: Have the patient or representative place the date and time that he or she signed the notice.

Page 2 of the Important Message from Medicare

First sub-bullet – Insert name and telephone number of QIO in bold: Insert name and telephone number (including TTY), in bold, of the Quality Improvement Organization that performs reviews for the hospital.

Second sub-bullet – The name of this hospital is: Insert/preprint the name of the hospital, including the Medicare provider ID number (not the telephone number).

Additional Information: Hospitals may use this section for additional documentation, including, for example, obtaining beneficiary initials, date, and time to document delivery of the follow-up copy of the IM, or documentation of refusals.

Provider Name: _____ Address: _____ City: _____ State:_____ Zip:_____ Phone: _____	**Notice of Medicare Non-Coverage for Home Health Care Services**

PATIENT INFORMATION

Patient Name:	Patient Number:

The Effective Date Coverage of Your Current Home Health Care Services Will End: _____

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Home Health Care services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.

If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;

- Neither Medicare nor your plan will pay for these services after that date.

If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO 1-855-408-8557 to appeal, or if you have questions.

Blue Advantage is an HMO plan with a Medicare contract. Enrollment in Blue Advantage depends on contract renewal.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved xx/xx/2015) OMB approval

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: 1-866-508-7145. TTY users should call 711.

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative Date

Form CMS 10123-NOMNC (Approved XX/XX/2015) OMB approval

Provider Name: _____ Address: _____ City: _____ State:_____ Zip:_____ Phone: _____	**Notice of Medicare Non-Coverage for Skilled Nursing Facility Services**

PATIENT INFORMATION

Patient Name:	Patient Number:

The Effective Date Coverage of Your Current Skilled Nursing Facility Services Will End: _____

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current Skilled Nursing Facility services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above,
- Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: KEPRO 1-855-408-8557 to appeal, or if you have questions.

Blue Advantage is an HMO plan with a Medicare contract. Enrollment in Blue Advantage depends on contract renewal.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved xx/xx/2015) OMB approval

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information: 1-866-508-7145. TTY users should call 711.

Additional Information (Optional):

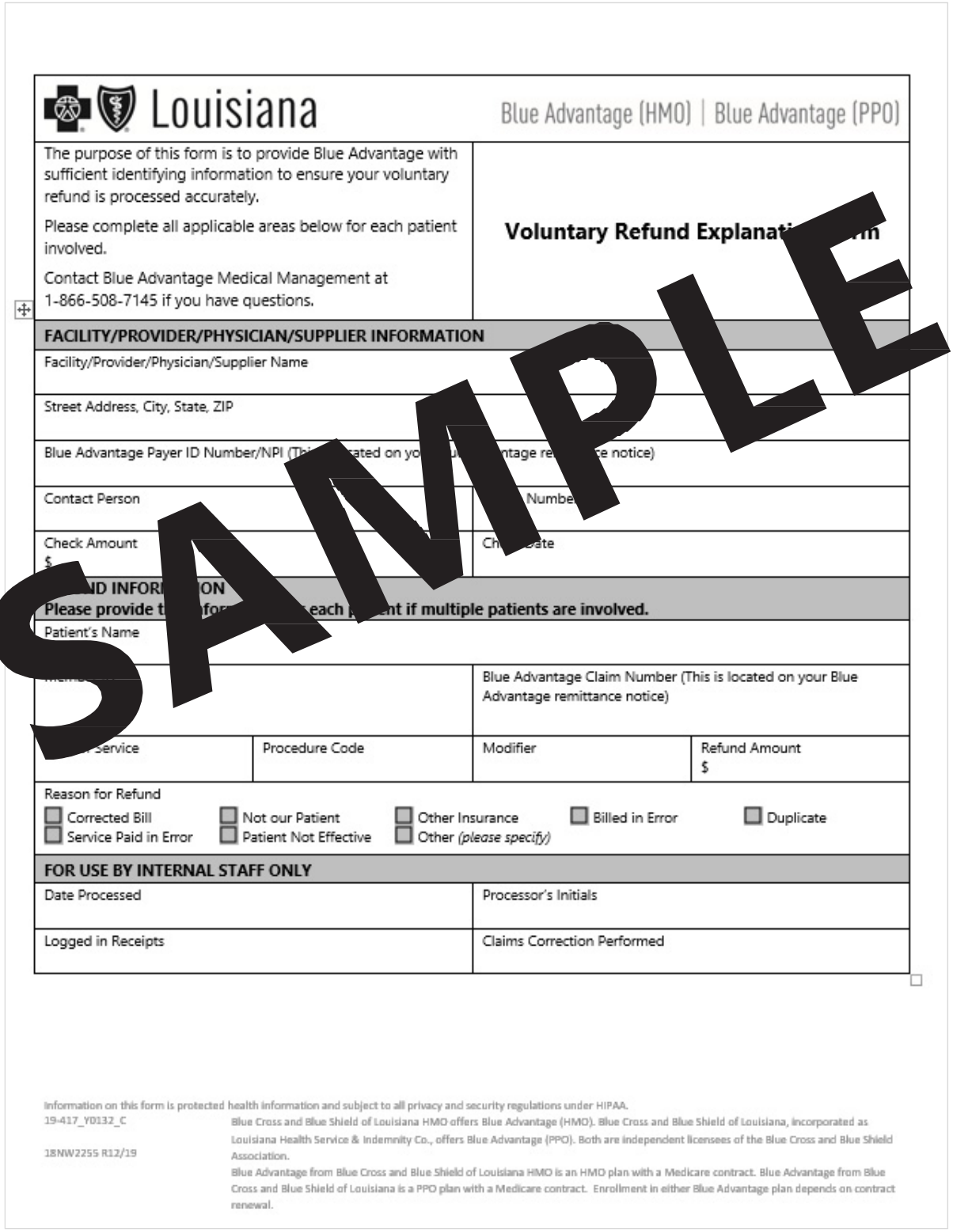
Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

Signature of Patient or Representative Date

Form CMS 10123-NOMNC (Approved XX/XX/2015) OMB approval

Voluntary Refund Explanation Form



Louisiana

Blue Advantage (HMO) | Blue Advantage (PPO)

The purpose of this form is to provide Blue Advantage with sufficient identifying information to ensure your voluntary refund is processed accurately.

Please complete all applicable areas below for each patient involved.

Contact Blue Advantage Medical Management at 1-866-508-7145 if you have questions.

Voluntary Refund Explanati m

FACILITY/PROVIDER/PHYSICIAN/SUPPLIER INFORMATION

Facility/Provider/Physician/Supplier Name

Street Address, City, State, ZIP

Blue Advantage Payer ID Number/NPI (Thi ated on yo ntage re e notice)

Contact Person

Numbe

Check Amount
$

Ch ate

ND INFORM ON
Please provide t infor each p nt if multiple patients are involved.

Patient's Name

Blue Advantage Claim Number (This is located on your Blue Advantage remittance notice)

Service	Procedure Code	Modifier	Refund Amount $

Reason for Refund

☐ Corrected Bill ☐ Not our Patient ☐ Other Insurance ☐ Billed in Error ☐ Duplicate
☐ Service Paid in Error ☐ Patient Not Effective ☐ Other *(please specify)*

FOR USE BY INTERNAL STAFF ONLY

Date Processed

Processor's Initials

Logged in Receipts

Claims Correction Performed

SAMPLE

Information on this form is protected health information and subject to all privacy and security regulations under HIPAA.

19-417_YD132_C

18NW2255 R12/19

Blue Cross and Blue Shield of Louisiana HMO offers Blue Advantage (HMO). Blue Cross and Blue Shield of Louisiana, incorporated as Louisiana Health Service & Indemnity Co., offers Blue Advantage (PPO). Both are independent licensees of the Blue Cross and Blue Shield Association.

Blue Advantage from Blue Cross and Blue Shield of Louisiana HMO is an HMO plan with a Medicare contract. Blue Advantage from Blue Cross and Blue Shield of Louisiana is a PPO plan with a Medicare contract. Enrollment in either Blue Advantage plan depends on contract renewal.

Below is a summary of changes to the *Blue Advantage Provider Administrative Manual*. Minor revisions not detailed in the summary include modifications to the text for clarity and uniformity, grammatical edits and updates to web links referenced in the document.

January 02, 2020

Introduction – Section updated

Plan Information Contact List

- **Blue Advantage Provider Directory** – Section added
- **Authorizations** – Section updated
- **Pharmacy** – Section updated
- **Provider Credentialing & Data Management** – Section updated
- **Reference Laboratories** – Update title
- **Who Do I Contact if I Have Questions?** – Section updated

General Information

- **Provider Assistance** – Section removed
- **Provider Preclusion List** – Section updated
- **Blue Advantage Member ID Card** – Section updated
- **Credentialing Program** – Section added

Provider Roles and Responsibilities – Revised section title

- **Sanctions under Federal Health Programs and State Law** – Section added
- **Misrouted Protected Health Information (PHI)** – Section added
- **Professional Manner** – Section added
- **Provider and Member Communications** – Section added
- **Preventive Health Guidelines** – Section updated
- **The Role of the Primary Care Provider (PCP)** – Section added
- **The Role of the Specialists** – Section added
- **Blue Advantage Provider Portal** – Section updated
- **Covering Physician Policy** – Section updated

Operations

- **Advanced Directives** – Section added
- **Fraud, Waste and Abuse** – Section updated

Medical Management

- **Blue Advantage affirms** – Section added
- **Provider Authorizations and Notifications** – Section updated
- **Initial, Concurrent Review and Discharge Planning** – Section updated
- **Adverse Initial Organizational Determination Process** – Section updated
- **Health Risk Assessments** – Section updated

Behavioral Health and Substance Abuse Services – Section updated

Case Management – Section updated

Out-of-area Care/Urgent Authorization – Section title updated

Pharmacy Management

Pharmacy Network – Section updated

Medicare Part D Formulary – Section updated

Medicare Part D Benefit – Section updated

90-Day Supply: Member Cost-Savings and Improved Adherence – Section updated

Medicare-Covered Drugs (also called Medicare Part B Drugs) – Section updated

Expedited Timeframes for PA Requests – Section updated

Opioid Utilization Review and Controls – Section updated

Claims and Billing Guidelines – Section title updated

Claims and Electronic Data Submission – Section updated

Provider ID via Paper Claims – Section updated

Timely Filing Requirements – Section updated

Other Medicare Advantage Services – Section added

Medicare Dual Eligible Special Needs Plans – Section added

Samples of Forms

All Forms – Sample forms replaced with most update version

January 09, 2020

Plan Information Contact List

Authorizations – Blue Advantage Medical Management phone number updated

Blue Cross and Blue Shield of Louisiana/HMO Louisiana, Inc.
P.O. Box 7003
Troy, MI 48007

1-866-508-7145
TTY users call 711
8 a.m. to 8 p.m., seven days a week

Access our Blue Advantage Provider Portal through iLinkBlue
www.BCBSLA.com/ilinkblue >Blue Advantage under the "Other Sites" section.