PROVIDER REFERENCE GUIDE

(HMO/PPO)

Missouri & Kansas | 2021

LAST UPDATE 03/02/2021

Kansas City | BLUE MEDICARE ADVANTAGE

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GENERAL INFORMATION

PLAN INFORMATION CONTACT LIST

Blue Medicare Advantage	
Customer Service **(866) 508-7140** For the hearing impaired, dial 711 Fax **(877) 549-1746** Providers.BlueKC.com Email: customerservice@BlueKCma.com	For inquiries such as claim status, claim payment issues or adjustment requests, member eligibility, benefit verification and prior authorizations. **Mailing Address:** Central Operations (COPS) Blue KC MA P.O. Box 419169 Kansas City, MO 64141
Provider Correspondence/Claims Address	Electronic claims submission is encouraged; follow the Blue KC electronic claims process. Blue Medicare Advantage correspondence, **medical** and **behavioral health** claims, use the following address unless otherwise noted: Central Operations (COPS) Blue KC MA P.O. Box 419169 Kansas City, MO 64141
Compliance/Fraud, Waste and Abuse (FWA) Call **(866) 508-7140** and ask for Compliance Department Compliance/FWA Hotline: **(844) 227-1790**	For questions related to: • Blue Medicare Advantage Compliance Program and Code of Conduct • Provider responsibilities relative to the Compliance Program, including required training • Reporting any suspected or actual violation of regulations, laws, policies or procedures • Fraud, waste and abuse relative to Blue Medicare Advantage Program.
Utilization Management/Concurrent Review Call **(866) 508-7140** Fax **(877) 549-1744**- Prior Authorization Fax **(877) 549-1745**- Concurrent Review **Appeals/Grievance:** Fax (877) 549-1748	**Utilization Management:** For assistance with case management, prior authorization of inpatient admissions/discharges, medical procedures including DME, Orthotics & Prosthetics, and Part B Drugs. Providers can access self-service tools options for medical services and medical drug (Part B drug) prior authorization requests by visiting the Providers.BlueKC.com Provider Portal. **Concurrent Review:** Evaluate continued hospital, Acute Rehabilitation or prior authorization to Skilled Nursing Facility stay, Long Term Acute Care (LTAC), or Home Health provider for medical necessity and appropriateness. Concurrent review takes place during an inpatient stay as a follow-up to prior authorization.
Radiology Services Call **(888) 693-3211** Fax **(888) 693-3210** myportal.medsolutions.com	**eviCore** – For assistance with prior authorizations of outpatient, non-emergent, diagnostic imaging services including: • CT/CTA • MRI/MRA • NCM/MPI • PET

Blue Medicare Advantage	
Part D Coverage Determination: Call **(866) 508-7140** Fax **(844) 403-1028** **Mail Order:** Providers can submit prescriptions electronically via ePrescribing or fax: (800) 491-7997 **OptumRx Appeal Information:** Phone Number: 888-403-3398 TTY: 711 Fax: 877-239-4565 **OptumRX** c/o Appeals Coordinator P. O. Box 25184 Santa Ana, CA 92799	For prior authorization assistance for a formulary drug, a form for Part D Coverage Determination. Providers can access self-service tools for pharmacy drug prior authorization requests by visiting Providers.BlueKC.com Provider Portal and submitting clinical information for review. Employer Groups refer to the Member ID card for Pharmacy (Part D Prescription) contact information.
Behavioral Health Services Call **(877) 228-9370**	**New Directions Behavioral Health,** our behavioral health partner supports providers treating members with behavioral diagnosis and concerns. If you need immediate assistance accessing treatment resources, call New Directions Physician Consult line to speak with a behavioral health professional. Prior authorization is required for inpatient admissions.
Routine Dental Services Call **(844) 231-8312**	Dental services are managed by **DentaQuest** visit www.dentaquest.com**.**
Routine Vision Services Call **(866) 248-1947**	**EyeMed Insight**– Contracted provider for routine vision services, eye glasses, and other eye hardware. Members have a routine vision benefit. For Employer Groups, refer to the Member ID card for vision services contact information. Paper claims may be submitted to: First American Administrators Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111
Routine Hearing / Hearing Aid Services Call **(855) 541-3070** for locations	**TruHearing** – Contracted provider for routine hearing and hearing aid services. Members have a hearing benefit contingent on their plan type.

OUR MISSION

Our mission is to provide affordable access to healthcare and to improve the health of our members.

PROVIDER ASSISTANCE

As a contracted Medicare Advantage Primary Care Physician, you will work directly with your Provider Engagement Consultant who will provide support to you and your practice for the Medicare Advantage plans. One of their primary functions will be to assist you with specific online tools and web-based applications.

If you are not a contracted Medicare Advantage provider and require assistance, please reach out to our Customer Service Department. Should you need assistance beyond this department, ask to speak to your Provider Relations Representative.

OUR PRODUCTS

Blue Medicare Advantage HMO and PPO offers Medicare beneficiaries an all-in-one 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 Medicare Advantage HMO and PPO members as well as Blue Medicare Advantage Flex (no Part D) PPO may have a copayment or coinsurance they are responsible to pay for some covered services.

Blue Medicare Advantage HMO and PPO and Blue Medicare Advantage Flex (no Part D) PPO are available to Medicare beneficiaries in counties of Cass, Clay, Clinton, Jackson, Lafayette, Platte and Ray in Missouri, and Johnson and Wyandotte counties in Kansas.

Blue Medicare Advantage Essential PPO is the only plan offered to Medicare beneficiaries in Buchanan County Missouri.

Blue Medicare Advantage Spira Care HMO is available only to Medicare beneficiaries who reside in Johnson or Wyandotte counties in Kansas.

SELECTING A PRIMARY CARE PHYSICIAN

For Blue Medicare Advantage HMO Plans:
Upon enrollment in Blue Medicare Advantage, a member must choose a physician to be their primary care physician. In rare cases, if the member has not identified a primary care physician and we cannot verify their choice, a primary care physician will be assigned. The member may select a different primary care physician from the one assigned by contacting Customer Service.

For Blue Medicare Advantage PPO Plans:
Blue Medicare Advantage PPO does not require the member to choose a primary care physician, however, Blue KC believes in a patient-centered approach where the primary care physician assists in coordinating the member care. Blue KC encourages Blue Medicare Advantage PPO members to select a primary care physician they can help the member find the best specialist and work with them to diagnose or treat conditions.

A primary care physician serves as the member's total care coordinator for non-emergent care.

Primary care physicians are available to members 24 hours a day, 7 days a week through regular scheduling or on-call coverage. There will always be a doctor on call to help them.

CHANGING A PRIMARY CARE PHYSICIAN

It is important that members have a good relationship with their primary care physician, as they provide most of their care. A member may change his or her primary care physician to another Blue KC contracted primary care physician at any time for any reason. Members can do so by contacting Customer Service. The requested change will be effective the first day of the month following receipt of the member's request. Please remember that it is the member's responsibility, not the current or newly identified primary care physician, to facilitate this type of change.

In rare situations, a member may be retroactively assigned to a primary care physician. For example, the member's primary care physician may have terminated their contract without notification because of illness or death. Blue KC will assist the member in finding a new primary care physician as quickly as possible to promote continuity in healthcare and coverage, but there may be a slight time lapse that causes the assignment to have a retroactive effective date.

For Blue Medicare Advantage HMO members, we suggest providers put office procedures in place to confirm via our online member eligibility look up that you are the primary care physician of record prior to a member's appointment. You can find the online member eligibility look up tool on the Provider Portal at Providers.BlueKC.com.

COMPLIANCE RESPONSIBILITIES FOR PROVIDERS

As a Medicare Advantage Organization (MAO) with an established contract with the Centers for Medicare & Medicaid Services (CMS), Blue KC is required to communicate its compliance program requirements to providers and to ensure compliance with these requirements. Providers contracted to provide medical or administrative services to our Blue Medicare Advantage 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 KC in its efforts to comply with the laws, regulations and other requirements of applicable regulatory authorities; and to ensure that all healthcare professionals employed by or under contract to render Health Services to Blue Medicare Advantage members, including covering physicians, comply with these provisions.

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 health care service functions relating to Blue KC are excluded by the OIG/GSA, and should immediately communicate any such exclusion to Blue KC's Compliance Department.

REPORTING COMPLIANCE CONCERNS

Actual or suspected Medicare program noncompliance, potential fraud, waste and abuse, or any compliance concerns or violations relating to Blue KC or its members must be reported. Providers must ensure that employees or contracted entities that perform administrative or health care service functions are aware of Blue KC's expectation 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 is denoted in the front of this manual (see Plan Information Contact List section-page 6), and should be publicized or otherwise made available throughout your facilities.

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 regard to or 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 health care 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 member service areas (i.e., exam rooms, waiting rooms)

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

- Provide the names of all Medicare Advantage and/or Part D plan sponsors with which they contract and/or participate.
- Provide information and assistance in applying for the Medicare Low Income Subsidy (LIS)
- Make available and/or distribute plan marketing materials for a subset of contracted Medicare plans, so long as the provider offers the option of making available and/or distributing marketing materials to all plans with which they participate.
- Provide objective information on Medicare plan sponsors' specific plan formularies, based on a particular member's medications and health care needs should a beneficiary seek advice.
- Provide objective information regarding plan sponsors' plans, including information such as covered benefits, cost sharing and utilization management tools should a beneficiary seek advice.
- Refer their patients to other sources of information, such as SHIPs, their state Medicaid office, local Social Security office, Medicare website (medicare.gov) or the Medicare helpline (1-800-MEDICARE).
- Print out and share information with patients from the Medicare web site.
- If patients ask, you can provide the name of the plan marketing representative.

BLUE MEDICARE ADVANTAGE MEMBER ID CARD

Each member enrolled in a Blue Medicare Advantage plan will be provided with an identification card. This card contains demographic information about the covered member, as well as important coverage information such as primary care physician name and phone number, copayment responsibilities and important phone numbers.

Blue KC encourages providers to make a copy of the member's card for their records. We also encourage you to confirm with members each time you see them to determine if their insurance coverage has changed and verify you are their primary care physician.

You may confirm member eligibility, current assigned primary care physician, deductible, maximum out of pocket and COB information via the provider portal at Providers.BlueKC.com. It is the member's responsibility to present his or her member ID card at the time medical services are obtained.

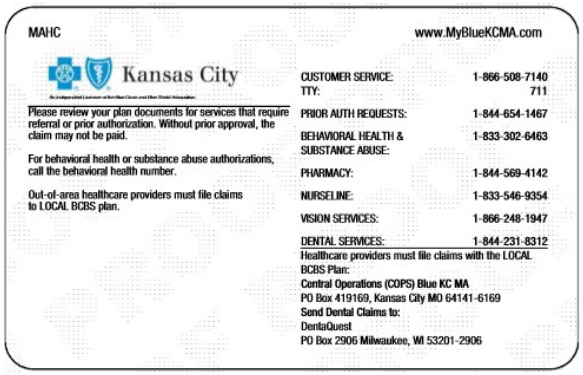
Benefits displayed do not represent all member benefits. Providers can access member benefit information via the provider portal at Providers.BlueKC.com or by calling Blue Medicare Advantage Customer Service.

Note: Effective January 1, 2021 Prefix's changed for Blue Medicare Advantage HMO and PPO plans.

- Blue Medicare Advantage HMO prefix RKC changed to RRK.
- Blue Medicare Advantage PPO prefix RKQ changed to RKN.

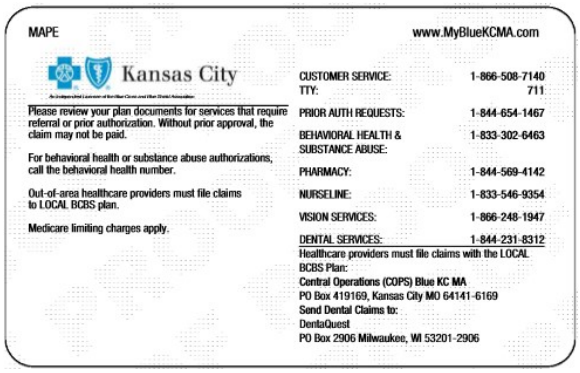
Below are examples of Blue Medicare Advantage Member ID cards:

Medicare Advantage Complete (HMO) (PREFIX RRK)

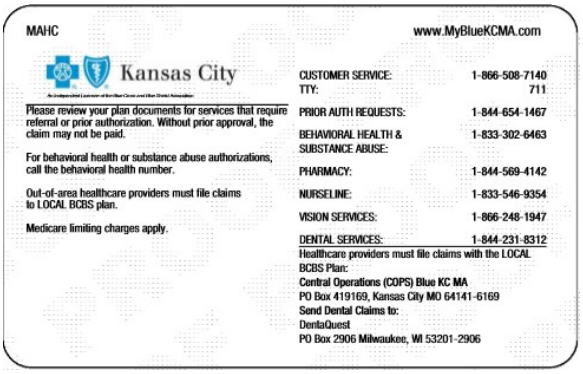


Blue Medicare Advantage Plus (HMO) (PREFIX RRK)

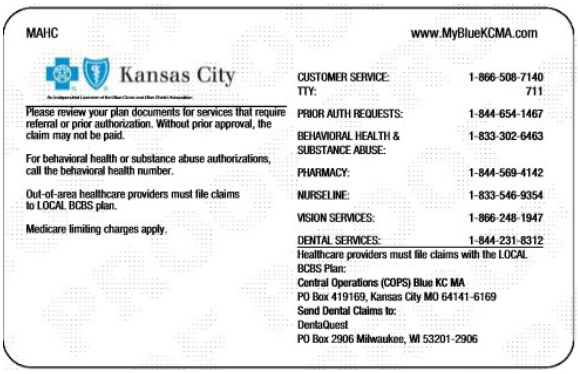
*Back of **Blue Medicare Advantage (PPO) for Blue Cross and Blue Shield of Kansas City Retirees***



Blue Medicare Advantage Access (PPO) (PREFIX RKN)

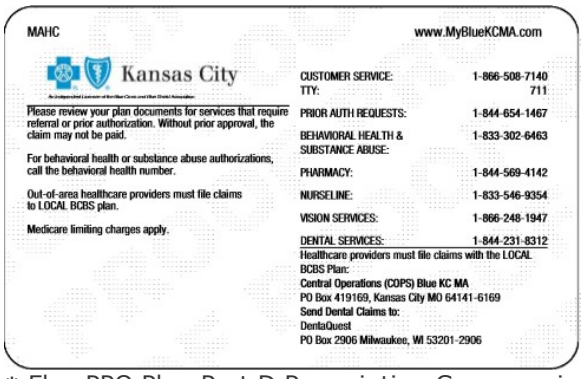


*Blue Medicare Advantage Essential (PPO) (PREFIX RKN)**



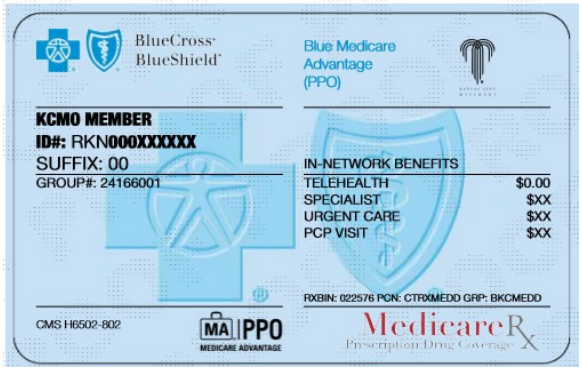
*Only plan offered in Buchanan County MO.

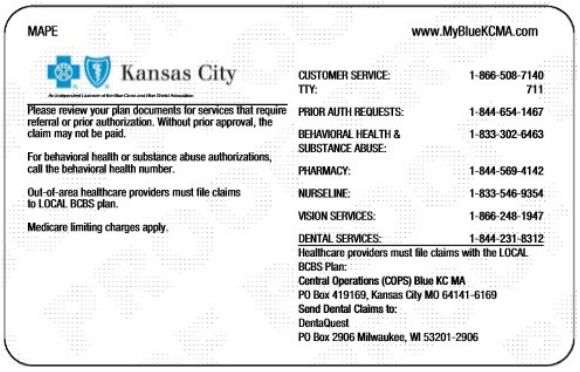
*Blue Medicare Advantage Flex (PPO) (PREFIX RKN)**



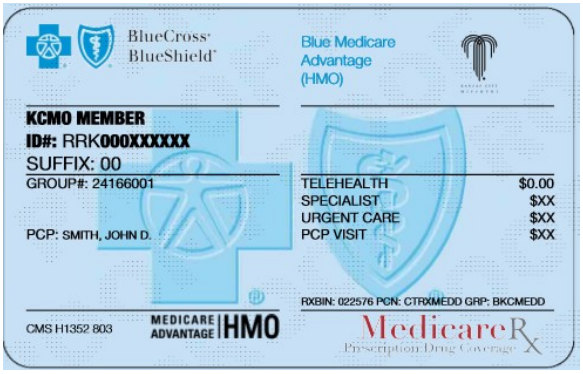
* Flex PPO Plan Part D Prescription Coverage is not part of the benefit package.

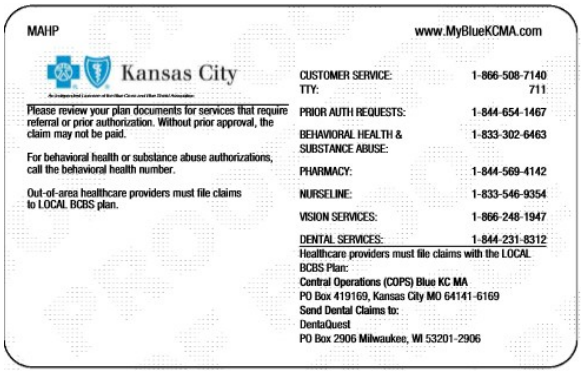
Blue Medicare Advantage-Plan 1 (PPO) City of Kansas City Retiree (PREFIX RKN)



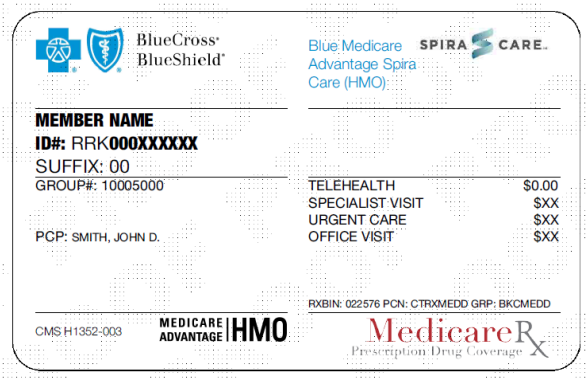


Blue Medicare Advantage-Plan 2 or Plan 3 (HMO) City of Kansas City Retiree (PREFIX RRK)

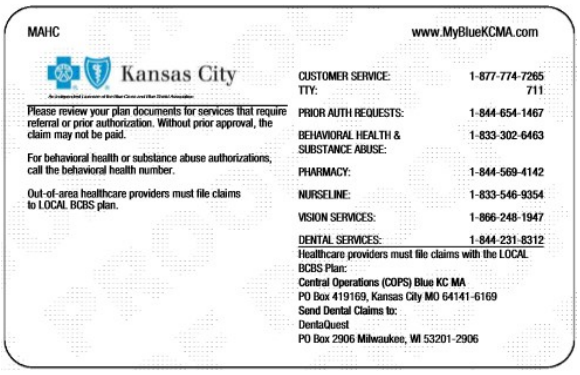




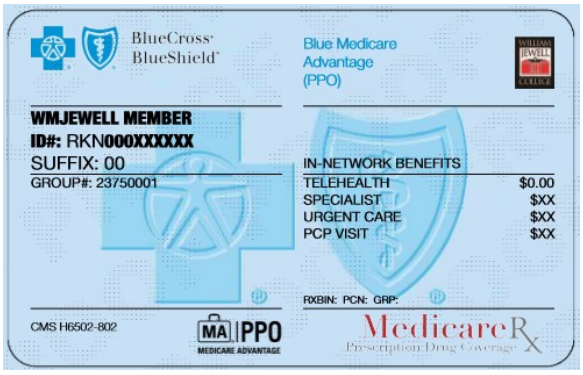
Blue Medicare Advantage SPIRA (HMO) (PREFIX RRK)

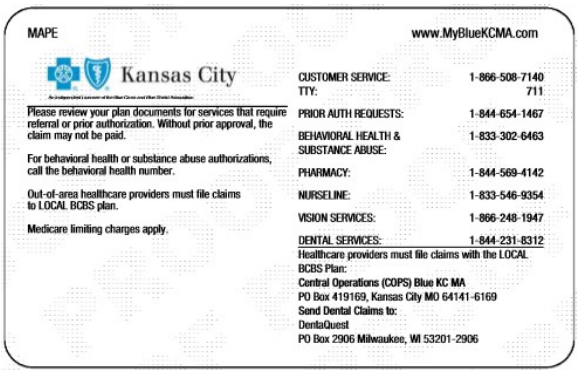


*Back of **Blue Medicare Advantage SPIRA (HMO)***

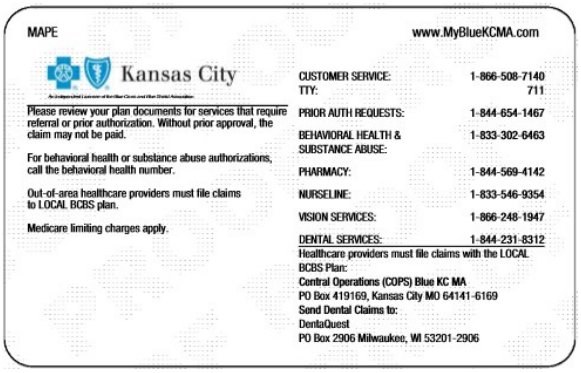


Blue Medicare Advantage (PPO) William Jewell College Retirees (PREFIX RKN)





Blue Medicare Advantage (PPO) for Blue Cross and Blue Shield of Kansas City Retirees (PREFIX RKN)



BLUE MEDICARE ADVANTAGE MEMBER RIGHTS & RESPONSIBILITIES

Each Blue Medicare Advantage member has the right:

- To be treated with dignity, respect and fairness at all times.
- To receive advice or assistance in a prompt, courteous and responsible manner.
- To confidentiality. All information concerning enrollment and medical history is privileged and confidential except when disclosure is required by law or permitted in writing. Blue Medicare Advantage members are entitled to access their medical records according to state and federal law; and with adequate notice, they have the right to review their medical records with their physician. Blue Medicare Advantage members also have the right to ask plan providers to make additions or corrections to their medical records.
- To choose a contracted primary care physician (that is accepting new patients). Members are asked to establish an ongoing relationship with their physician. Blue Medicare Advantage members have the right to change physicians at any time and for any reason.
- To get appointments and services within a reasonable amount of time (see Appointment Scheduling and Waiting Time Guidelines section for specifics).
- To participate fully in decisions about their health care and have providers explain things in a way that they can understand. This includes knowing all of the treatment choices recommended for the condition, no matter what they cost or whether they are covered by Blue Medicare Advantage.
- To ask someone such as a family member or friend to help with decisions about health care. 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.
- To make a complaint if they have concerns or problems related to coverage or care.
- To information about Blue KC, its services, its participating physicians and other health care providers providing care and members' rights and responsibilities.
- To discuss healthcare concerns or complaints about Blue KC with those responsible for their care or with Blue KC, and to receive a response within a reasonable time period.
- To receive information in a form they can understand, including obtaining interpretive services to provide information in the language of their choice.

CULTURAL COMPETENCY

Cultural competency is a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural similarities and differences. It is important to understand that differences in culture, language, communication styles, and beliefs influence health and healthcare and interactions our 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 have access to and participate 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 that 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.

SECOND OPINIONS

Blue Medicare 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 and/or if the member so desires, a third opinion, provided by a third provider can be sought. Second and third opinions should be obtained within the Blue Medicare Advantage contracted provider network. If there is no qualified physician to perform the second or third opinion consultation within the Blue Medicare Advantage provider network, the primary care physician will need to contact the Utilization Management Department for assistance and approval to go outside of the network for the consultation.

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")
- A "Durable Power of Attorney for Health Care."

A Healthcare Directive is a document that allows an individual to state in advance their wishes regarding the use of life-prolonging procedures. It may be relied upon if the individual becomes 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 healthcare is a signed, dated and notarized legal document that allows an individual to appoint someone to make health care 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 Medicare Advantage participating physicians 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 the member's medical record.

Individuals may change their mind 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 with updated copies given to their health care providers.

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

There are multiple resources within the community and on-line to assist with the completion of these forms and they are available at no charge from each state's website. Additionally, our Blue KC Case Managers are also available to help members talk through these important decisions.

MEMBER SERVICES

Blue Medicare Advantage Customer Service Representatives are available to assist members, once they have enrolled in the plan. These representatives are the member's contact at Blue Medicare Advantage and provide a variety of information to the member. Members should contact Customer Service if they have questions concerning the plan, such as:

- The role of the primary care physician
- 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 into Customer Service on the member's behalf and request that a representative call the member to assist the individual.

EXPLANATION OF BENEFITS

Blue KC issues two types of EOBs 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. (i.e., requires a corrected procedure code or requires 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 which phase of the Part D benefit the member is currently in.

Members can also obtain real time information online at MyBlue KCMA.com once they establish a secure user ID and password. EOB's are only issued if the member has had claims activity the prior month.

MAKING CHANGES IN HEALTH CARE 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 health care and drug coverage options for the upcoming year and are able to make changes that will be effective January 1st of the following year.

Open Enrollment Period (OEP)
For beneficiaries that enrolled in a Medicare Advantage Plan, CMS opens up the Open Enrollment Period (OEP) that will allow that beneficiary to make a change. Beneficiaries are allowed to change to another Medicare Advantage Plan or back to Original Medicare (and join a separate Medicare drug plan). The beneficiary can only make one change during this period.

Special Election Period (SEP)
Individuals may also qualify for what is called a Special Election Period (SEP). A 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 (note: 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 Part 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
Open Enrollment Period Time to change from a Medicare Advantage plan to another Medicare Advantage plan or back to Original Medicare.	From January 1 to March 31	First day of next month after plan receives the disenrollment request
Special Election Periods (SEP) for limited special circumstances such as: • The beneficiary has a change in residence that moves them in to or out of the plan's service area • 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

PRIMARY CARE PHYSICIAN & BLUE KC WEB BASED APPLICATION (QUALITY & RISK ANALYTICS)

BLUE KC WEB BASED APPLICATION

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

Accessing the application tool is done through the Blue KC Provider Portal. To gain access to Web Based Application (Quality & Risk Analytics) tool, you must first have login credentials for the Blue KC's Provider Portal at Providers.BlueKC.com. Reach out to your MA Provider Engagement Consultant to complete the approval process.

Once you have been granted permissions to this application (Quality & Risk Analytics), you can access the tool at Providers.BlueKC.com. Single sign on functionality exists between the Blue KC Provider Portal and the application tool (Quality & Risk Analytics).

PRIMARY CARE PHYSICIAN MEMBER ACCESS

Blue KC encourages all new members to build a relationship with their primary care physician and not wait until there is a health problem. Blue KC understands that medical issues can arise prior to the member becoming established with the practice and those problems need to be addressed by the primary care physician'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.

APPOINTMENT SCHEDULING AND WAITING TIME GUIDELINES

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

Primary care physician – new patient	• Within 30 days of the member's effective date on the primary care physician's panel – to be initiated by the primary care physician's office
Routine care without symptoms	• Within thirty (30) days
Non-routine care with symptoms	• Within 5 business days or 1 week
Urgent Care	• Within 24 hours
Emergency	• Must be available immediately 24 hours per day, 7 days per week via direct access or coverage arrangements.
OB/GYN	• 1st and 2nd Trimester within 1 week 3rd Trimester within 3 days • OB emergency care 24/7
Phone calls into the provider office from the member	• Same day; no later than next business day.

- Routine care without symptoms include physical exams and wellness
- Non-Routine care with symptoms include rashes, coughs and other non-life-threatening conditions
- Urgent Care means medical attention is needed right away for an unforeseen illness or injury, but the member's health is not in serious danger.
- Emergency means medical attention is needed in connection with a sudden onset of a medical condition (including pain), that a prudent layperson with an average knowledge of health and medicine would reasonably expect with the absence of medical attention could result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

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

Members who are late for their scheduled appointment may not be able to be seen within fifteen minutes.

PROVIDER PORTAL

ACCESSING THE PROVIDER PORTAL WEB SITE

Providers with Internet access can quickly find answers to questions about members, providers and benefit plans by visiting Blue KC's Provider Portal at Providers.BlueKC.com.

Blue KC's Provider Portal gives 24/7/365 access to:

- Member information such as the status of a claim, eligibility of a member, benefits or coverage of a member's plan, remittance advices, explanation of benefits (EOB) and medical policies.
- A Provider Directory, which enables members and providers to find addresses and telephone numbers for network providers affiliated with Blue KC Medicare Advantage. Providers can use this site to verify the accuracy of their own contact information.
- The organizational administrator who has the responsibility of adding and managing the users in a Provider's practice/facility who will need access to the portal. Please do not share login information, HIPAA requires that each user have their own username and password. After login, access under the header titled Account Administration, the Manage Users area is on the right.
- You must sign in once every 30 days or the password will expire. With regular usage, passwords will expire every 120 days. Contact your Organizational Administrator or call 816-395-3700 for a password reset.
- Providers must login to the Providers.BlueKC.com to access claims and eligibility information, forms, benefits or coverage of a member's plan, remittance advices and medical policies. Login is not necessary to use Find a Doctor.

REGISTERING FOR PORTAL ACCESS

Request Access, follow these steps:

1. From Providers.BlueKC.com click **REGISTER NOW**.
2. Complete the form.
3. Click **SUBMIT**.

You will receive an email with login information.

LOGIN: Follow these steps to login:

1. Go to Providers.BlueKC.com.
2. Type Username and Password, then click **LOGIN**.

All alphabetic characters in usernames and initial passwords are lower case.

Navigation: After **LOGIN**, the Home page will be displayed. From the Home page, use the navigation menu cross the top or left side of the page:

- Claims/Eligibility
- Communications
- Resources
- Forms
- Medical Policies
- Account Administration

In the upper right see Find a Doctor, Contact and the **LOG OFF** links.

VERIFYING MEMBER ELIGIBILITY FOR ALL PROVIDERS

Blue KC encourages all participating providers to utilize Providers.BlueKC.com for standard member eligibility and plan benefit confirmation. Once verification is in place, Provider shall provide timely accessibility to members. An individual's possession of a membership ID card is not a guarantee of eligibility or benefits. Always verify eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Current member eligibility can be found online by going to Providers.BlueKC.com. Secure log-in credentials (user name and password) are needed to access this information. Directions to secure this access are noted under the **Provider Portal** section of this guide.

Electronic Inquiries: Real-time eligibility request and response (270/271) is available. Specific details found at Providers.BlueKC.com under **RESOURCES**- **EDI COMPANION GUIDE.**

ONLINE PRIOR AUTHORIZATION INQUIRY FOR ALL PROVIDERS

Blue KC encourages all participating providers to utilize Providers.BlueKC.com for standard prior authorization request submission and status. Always verify eligibility and benefits in advance of providing (non-urgent or non-emergent) services.

Current prior authorization status and directions can be found online by going to Providers.BlueKC.com. Secure log-in credentials (user name and password) are needed to access this information. Directions to secure this access are noted under the **Provider Portal** section of this guide.

Electronic Inquiries: Real-time status request and response is available. Specific details found at Providers.BlueKC.com under **RESOURCES**- **PRIOR AUTHORIZATION.**

ONLINE CLAIM INQUIRY FOR ALL PROVIDERS

Blue KC encourages all participating providers to utilize the Provider Portal for standard claims status checks.

Once a claim has been submitted, it can be found online by going to Providers.BlueKC.com. Secure log-in credentials (user name and password) are needed to access this information. Directions to secure this access are noted under **Provider Portal** section of this manual.

Electronic Inquiries: Real-time claim status request and response (276/277). Specific details found at Providers.BlueKC.com under **RESOURCES- EDI COMPANION GUIDE**.

ONLINE PRESCRIPTION DRUG COVERAGE DETERMINATION FOR ALL PROVIDERS

A prescribing provider can submit a prescription drug coverage determination request online through the Provider Portal. There are a variety of reasons in which a coverage determination may be needed (i.e., request for coverage of a non-formulary drug, tier exceptions, step therapy, etc.). This request goes directly to the prior authorization department. A provider can also submit a request for a redetermination (appeal) for a Part D prescription drug online. For additional information, see the Part D and Part B Drugs Requiring Prior Authorization section of this manual.

For Employer Groups, refer to the Member ID card for Prescription Drug coverage benefit contact information.

TERMINATING A RELATIONSHIP WITH A PATIENT

It is the physician's responsibility to take reasonable efforts to develop and maintain a positive patient-physician relationship. In the event that such a relationship cannot be established, the steps outlined below are to be followed:

1. Call Blue Medicare Advantage Customer Service and notify them that you are unable to establish and/or maintain a positive physician-patient relationship. Provide your name and title, member's name and ID number, and a contact number where you can be reached. Do not send correspondence to the member terminating a relationship prior to notifying us.

2. The Customer Service Department will transfer your contact information to the Quality Improvement Department who will contact you within 1 business day to collect the documentation needed to process the termination. The Quality Improvement Department will inform you of the types of documentation you may submit supporting your position, including phone logs and medical record documentation. Documentation must demonstrate a diligent effort including a minimum of three attempts by the primary care physician to establish and/or maintain a relationship.

3. Blue KC may choose to attempt contact with the patient/member prior to additional action by the physician office. You will be informed if this step will be taken.

4. If Blue KC chooses not to make contact with the patient/member, you will be directed to send a certified letter (with return receipt) to the member giving, in detail, the reason for terminating the relationship. The letter will include a date by which the member is expected to make a primary care physician change. The physician must allow the member a MINIMUM of 30 days in which to select a new primary care physician. The member will be effective with the new primary care physician the first day of the next month following the change. Until that time, you will be responsible for all aspects of the member's healthcare needs.

5. If the member does not choose a new primary care physician, Blue KC will assign the member to another primary care physician within reasonable proximity to the member's residence or your practice. Blue KC will make every effort to successfully transfer the member to a new primary care physician by the date specified in the letter. Note that the member will have the ability to select another primary care physician within the primary care physician's independent practice association, if applicable, but not within your specific practice.

6. You must assist in the member's transfer of care by providing a copy of the complete medical file and, if relevant, discussing care issues with the newly selected primary care physician.

Note: A request to terminate the relationship with a member must be based on an inability to establish or maintain an effective physician-patient relationship. You may not terminate the physician-patient relationship with a member:

- During an "acute episode" of care such as hospitalization or skilled nursing facility (SNF) stay;
- On the basis of the member's health status, the cost of providing care;
- Due to a family member being terminated from the practice; or
- The member being institutionalized or home-bound.

Notify the Customer Service department if a member is disruptive to the practice or is abusing benefits. Document specific behaviors that are interfering with your ability to establish and maintain a positive physician-patient relationship and retain any correspondence to and/or from the patient.

MEDICAL RECORDS

Blue KC has adopted guidelines for the maintenance of medical records within participating physician 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 records 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 ten years.

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

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

- Paper charts must contain the following:
  - Medical records are organized and do not contain loose papers
  - All sheets contain the member's name, date of service and another unique member 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 member 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 none
  - Prevention 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 member'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 (for dates of service prior to January 1, 2018), 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

Physicians are expected to achieve an 80% score, at a minimum, on the Medical Record Reviews. Medical records of physicians 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 physician'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 KC may request medical record documentation to investigate a member grievance or appeal. In this event, the practitioner must respond within the timeframe stated in 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 with the physician and provides details of specific coding/ documentation concerns to the physician and/or the physician'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.

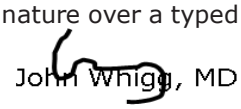
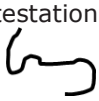
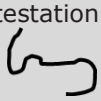
PHYSICIAN SIGNATURE GUIDELINES

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 Blue KC and/or other CMS contractors.

CMS allows the use of handwritten or electronic signatures. Electronic signatures must be date and time stamped. Note that the individual performing the service must be the provider who signs the documentation.

See next page for more information on CMS signature guidelines.

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:** 	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 letter head lists 3 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 signature log or ○ An attestation statement **Example**: 	X	
6. Illegible signature NOT over a typed/printed name and NOT on letterhead, and the documentation is Unaccompanied by: ○ A signature log or ○ 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 signature log or ○ An attestation statement	X	
9. Initials NOT over a typed/printed name Unaccompanied by: ○ A signature log or ○ 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 AND/OR ADDENDUMS

Any correction, addition or change in any member record made more than 48 hours after the final entry is entered in the record and signed by the physician 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 and/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/OR TRANSFER OF MEDICAL RECORDS

When a member changes primary care physician, the individual 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 ten (10) business days from receipt of the request.

Participating physicians and other providers, including facilities, are required to comply with Blue KC'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 the Centers for Medicare and Medicaid Services (CMS) are allowed access to member records of Blue Medicare Advantage members for specific purposes.

TRANSFER OF INFORMATION BETWEEN PROVIDERS

During the office orientation, Blue Medicare Advantage Engagement Specialists will educate the provider/physician and/or their office staff on the following to promote continuity of care for Blue Medicare Advantage members:

Primary Care Physicians:
When a primary care physician refers a member to a specialist, the primary care physician should forward relevant notes, x-rays, reports or other medical records to the specialist prior to the member's scheduled appointment.

Specialists:
Specialists are required to report preliminary diagnosis and treatment plans to the member's primary care physician within two (2) weeks from the date of the first office visit. The specialist should provide the primary care physician with a detailed patient summary report within two weeks after the completion of the evaluation or treatment and within two (2) weeks of each subsequent encounter.

Confidentiality

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

TERMINATION FROM BLUE MEDICARE ADVANTAGE

While Blue KC makes reasonable efforts to resolve provider issues, contracted providers may voluntarily terminate their participation in the Blue Medicare Advantage network without cause by **providing 60 days advance written notice to Provider Relations**.

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

Blue KC may terminate the participation of an individual provider for cause and give notice in accordance with the terms of the Blue Medicare Advantage addendum.

Providers should refer to their Blue Medicare Advantage contract addendum for specific requirements regarding termination notice and terms.

CHANGES IN YOUR PRACTICE

CMS requires payers to keep the most accurate and current roster information. Blue KC requires Providers to update their information in three separate places to ensure Provider payment and directory accuracy. Information in all databases should **match**. Inaccurate or inconsistent information will delay Provider payments. Providers should update information at:

- CMS PECOS https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
- NPPES https://nppes.cms.hhs.gov/#/
- CAQH https://proview.caqh.org/Login/Index?ReturnUrl=%2f

Updates and changes must be provided to Blue KC on a ***quarterly*** basis at minimum using the online attestation service from CAQH. Submit all updates (change form, roster, change file, etc.) to Provider_Data@BlueKC.com . Information that needs to be communicated includes but is not limited to:

- Address, phone, fax or billing location
- Practice personnel – physician leaving, retiring or joining a different practice and/or staff that leave and should no longer have Provider Portal and ADSP access. You may be required to provide a current copy of the practice personnel roster.
- TIN or tax information
- NPI
- Ability to accept new patients
- Office hours
- Any other changes that affect availability to patients
- Services available at provider practices

We will advise you if additional information is necessary to process your request.

PROVIDER SATISFACTION SURVEY

Provider satisfaction is one of the central tenets of Blue KC. Periodically, we will survey the providers to garner feedback to identify key steps to ensure a high satisfaction level with our valued providers.

COVERING PHYSICIAN POLICY IN CAPITATED ARRANGEMENTS

Primary Care Physicians: If you are a primary care physician with a capitation arrangement with Blue Medicare Advantage, you need to make appropriate arrangement to pay a covering physician for services that he or she renders on your behalf.

UTILIZATION MANAGEMENT

For help in determining whether a service requires prior authorization or notification, refer to the Provider Portal or you may call the Medicare Advantage Blue KC Customer Service group at (866) 508-7140.

BENEFIT DETERMINATIONS

Providers with questions about a specific benefit or "covered services" should direct their queries to the Utilization Management Department. The Utilization 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 Blue KC has approved the service being requested. Blue KC utilizes the following resources for benefit and medical necessity determinations:

- Member's Evidence of Coverage (EOC) and Summary of Benefits (SOB)
- Medicare National Coverage Determinations (NCD), Local Coverage Determinations (LCD), Medicare Managed Care Manuals and Medicare Administrative Contractor (MAC)
- Milliman Care Guidelines (MCG)
- eviCore, a radiology benefits management vendor

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

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

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

- The reason the member needs to go out of network
- The name of the in–network provider(s) who have been consulted
- The medical records from the requesting physician and consulting physician(s).

Send all requests for benefit determinations to the Provider Correspondence address or fax noted in the Plan Information Contact List section (page 6) or call the Utilization Management Department to initiate a request.

For information regarding members' benefit plan and coverage, you may consult the Summary of Benefits and Evidence of Coverage documents at Providers.BlueKC.com.

PRIOR AUTHORIZATIONS AND NOTIFICATIONS

Prior authorization is the process of collecting and evaluating information in advance of authorizing the non-emergency use of facilities, diagnostic testing, and other services before care is provided. For most items, services and procedures requiring prior authorization, a request needs to be received at least 14 (fourteen) days prior to planned delivery of the service or item.

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

Prior authorization is performed telephonically or via fax with a review conducted by a representative of the Utilization Management Department, Medical Director and/or other 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 issue a denial of services based on medical necessity.

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

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

MEMBER DIRECT ACCESS SERVICES

For members who are not enrolled in a SpiraCare HMO plan, many services are available without a referral from their Primary Care Physician. These services include but are not limited to:

- Routine women's healthcare, which includes breast exams, mammograms, PAP tests and pelvic exams from a Blue Medicare Advantage contracted provider
- Flu shots and pneumonia vaccinations
- Urgent and emergency services from either a network participating provider or an out-of-network provider
- Dialysis services when the member is temporarily outside the Plan service area. We encourage the member to advise you or us prior to leaving the service area so that arrangements for maintenance dialysis can be made, including entry of an out-of-network prior authorization to enable automated claims payment for the dialysis treatment
- Routine eye care from Blue KC's contracted routine eye provider (EyeMed Insight) as applicable to Plan.
- Preventive dental care only from a Blue KC's contracted dental provider (DentaQuest) as applicable to Plan.
- Behavioral health service, including inpatient and outpatient mental health/substance abuse
- Telephone/remote device checks.
- Fitness program services from Blue KC's contracted fitness program (Silver Sneakers).
- Audiology evaluations from Blue KC's contracted provider (TruHearing).

NOTIFICATION REQUIREMENTS

Notification is the act of providing notice or alerting Blue KC of a particular service provided to an eligible member. The notification process permits eligibility verification, communication with the primary care physician and/or member, and identifies members for concurrent review, pre-service discharge planning and case management. The Utilization Management Department will accept this verbal notification from the scheduling specialist, the facility or the primary care physician.

All acute inpatient admissions require providers to notify Utilization Management within one (1) business day of the admission. Any admission to a post-acute setting (SNF, IRF, LTAC) requires a prior authorization and, once admitted, notification to Utilization Management within one (1) business day of admission.

An outpatient observation that is changed to an inpatient admission must be reported to Utilization Management within one (1) business day**.**

Providers can report hospital admissions to Utilization Management by phone, fax or portal (see numbers in Plan Information Contact List section- page 6). The phones are forwarded to a voice mail system during non-business hours. The fax is available 24 hours a day, 7 days a week. Notifications submitted via phone or fax will be confirmed by Utilization Management staff with a reference number. Notifications submitted via portal will automatically generate a reference number. *This reference number does not guarantee payment.*

The notification process serves to:

- Verify member eligibility;
- Screen for coverage/benefit exclusions;
- Identify if the facility is a Blue KC contracted facility;
- Notify the appropriate Utilization Case Manager of the admission (hospital) to begin review of continued stay appropriateness and early identification of potential discharge needs.

After Utilization Management has issued a pending reference number for the hospital admission, providers are instructed to submit clinical documentation to Blue Medicare Advantage within one (1) business day of admission to complete the notification process and receive an authorization for payment. The clinical information provided enables the Plan to initiate the concurrent review process (see section Concurrent Review and Discharge Planning).

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

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

Providers who are denied payment because notification/prior authorization is lacking cannot bill the member. Provider pay disputes must be submitted to the Plan in writing. Your request should outline the basis for the dispute and include documents supporting your position. Send your written claims dispute requests with all supporting documentation to Provider Correspondence (see Plan Contact Information List section-page 6).

CONCURRENT REVIEW AND DISCHARGE PLANNING

Concurrent review encompasses care management during the provision of services at an inpatient level of care or during an ongoing outpatient course of treatment. Concurrent review is conducted via fax or EMR utilizing MCG and Medicare guidelines.

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 continued benefit coverage and medical necessity
- Identification of continuing care needs to facilitate discharge to the most appropriate setting
- Discharge planning and coordination

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

- Provide clinical information to Utilization Management within one (1) business day of admission to obtain an initial length of stay authorization.
- Provide updated clinical information as requested by Plan staff within one (1) business day of request to obtain authorization for days beyond the initial length of stay authorization.
- Provide discharge dates to Utilization Management to issue final length of stay authorization for claims payment and facilitate successful transitions to next level of care.

Using MCG and Medicare guidelines, the clinical reviewers perform prospective review for requests of extended care facility (rehabilitation hospital, long term acute care hospital (LTAC) and skilled nursing facility) services, concurrent reviews for continued acute inpatient reviews, rehabilitation hospital, LTAC and skilled nursing facility services to determine if the case meets criteria for authorization and when needed, retrospective requests for emergent inpatient services provided by out of network facilities. When a clinical review demonstrates the criteria are not met, the case is referred to a Medical Director for review.

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

The services are medically necessary based on the criteria referenced. "Appropriate" means that 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/or 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 which 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 staff regarding the member's future needs. Once the physician has communicated what is needed to facilitate the discharge of the member, the Utilization Case Manager coordinates the 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 Utilization 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 patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services must also be reasonable and necessary to be covered. Notification is not required for observation services that are 48 hours or less. Claims for observation stays exceeding 48 hours will not be paid. If the hospital chooses to convert the observation stay to inpatient, the health plan must be notified immediately.

Peer-To-Peer Consult with Medical Director:

- When a Blue KC Medical Director has determined that the medical necessity criteria have not been met, the requesting provider is then notified of an "intent to deny." The requesting physician then has the option to request a peer-to-peer discussion with the Blue KC Medical Director. The attending physician may delegate this responsibility to a non-physician provider (Nurse Practitioner, Physician Assistant, etc.). However, there will not be an opportunity for a second Peer-to-Peer should the outcome of that initial discussion be to uphold the initial decision. The notification of our "intent to deny" will be called to the requesting provider with timelines for completion given and the phone number to call. Providers can also initiate a peer-to-peer discussion by contacting the plan's utilization case manager for your facility.

CHANGE IN HEALTHCARE COVERAGE DURING INPATIENT STAY

Per Chapter 4 of the Medicare Managed Care Manual, when fee-for-service and Medicare Advantage beneficiaries are inpatients at the time they become enrolled in Blue Medicare Advantage and are in:

- An acute care setting - their previous carrier is financially responsible for all inpatient services through discharge from the facility. This applies to inpatient stays at any acute or long-term care hospital or an acute rehabilitation hospital.
- A covered skilled nursing stay - Blue KC Medicare Advantage assumes payment beginning on the member's effective date, if the stay remains medically necessary.

NOTICE OF DISCHARGE FROM AN INPATIENT FACILITY, HOME HEALTH OR CORF

The Important Message from Medicare (IM) is an existing statutorily required notice designed to inform Medicare beneficiaries that their covered hospital care 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 day of discharge.

The Notice of Medicare Non-Coverage (NOMNC) is issued to a Medicare beneficiary notifying them that their skilled services, home health care, or CORF services are about to end. Per CMS guidelines, the NOMNC must be given to the member and/or their identified representative a minimum of two days prior to their discharge even if they agree the service should end. A signed NOMNC must be faxed to Utilization Management. Contact information for Utilization Management is located in the Plan Information Contact List section (page 6) of this manual.

POST-ACUTE ADMISSIONS (SNF, LTAC, IP REHAB)

Please note that all post-acute admissions (SNF, LTAC, Inpatient Rehabilitation) do require a prior authorization. The authorization, once provided, is valid for 48 hours. If the admission does not occur within that timeframe, the requesting facility must submit a new request with updated clinical information. Once a member is admitted to a post-acute facility (head in bed), telephone notification to the plan is required.

Post-admission Review -- Facility Expectations:

SNF: Upon notification that the member has been admitted, the first clinical review must be provided no later than the end of the next business day. The SNF is required to submit any physician notes, the nursing documentation and all applicable therapy evaluations. Upon receipt of that assessment, the Plan will determine additional days to be authorized.
Inpatient Rehabilitation: Upon notification that the member has been admitted, the post-admission assessment must be provided by the end of the third IRF day. This will include the physician's documentation as required by CMS, all therapy evaluations, and the plan of care for the stay. Additional days will be authorized following the review of this information. Preference for timing of subsequent reviews will be to coincide with the Team Conferences but may not always be possible.
LTAC: Upon notification that the member has been admitted, the post-admission assessment must be provided within 3 days. This will include physician documentation, respiratory therapy notes, labs, radiology, nursing notes, therapy notes, and any other relevant documentation. Additional days may be authorized following review of information.

HOSPITAL READMISSION

Per Blue KC readmission policy, reimbursement for the readmission to the same facility for symptoms related to, or for the evaluation and management of, the prior stay's medical condition within a 30-day window will not be made by Blue KC. Payment for the second admission is considered to be included in the initial admission reimbursement, except for unrelated, planned or unavoidable readmissions, which will be subject to medical review.

OUT-OF-NETWORK SERVICES

For Blue Medicare Advantage HMO Plans:

Blue KC strives to provide a comprehensive network of providers to meet our members' healthcare needs. Participating physicians help ensure the affordability and success of their member's health care by recommending them to participating network providers. In rare instances, a member may have a medical need for a non-emergent service that cannot be met by a network provider. If the primary care physician is unable to recommend a network provider, prior authorization from the Utilization Management Department will be required before the member can be directed to a non-participating provider.

If a primary care physician recommends an out-of-network (OON) specialist, contact the Utilization Management department (see Plan Information Contact List section (page 6) at the beginning of this manual). Utilization Management will perform the following activities:

1. Confirm the provider is OON.
2. If OON, search the provider directory to determine if there is an in-network specialist, of the same type as being requested, within a 30-mile radius of the member's residence. If there is not, the OON request is approved.
3. If there is an in-network specialist, Utilization Management may deny the OON requests and will assist the member in identifying an in-network option. If the primary care physician does not want to redirect, the primary care physician is asked to send in clinical information to Utilization Management to support the need for the OON specialist.
4. If clinical information is sent, it is reviewed against Transition of Services criteria, below. If it does not meet criteria, a denial letter is sent to the member and the requesting provider that also explains appeal rights.

Transition of Services criteria:

- The services requested are not available from contracted providers within a 30-mile radius of the member's home address. EXCEPTION: Transplant services.
- 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 that 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 of pregnancy 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 prior-authorized by Blue KC's Utilization Management Department.

For Blue Medicare Advantage PPO Plans:

- The member can choose to receive care from out-of-network providers.
- Providers that are not contracted are under no obligation to treat the member, except in emergency situations.
- Providers that are not contracted must be a Medicare Accepting provider for out-of-network services
- Blue KC will cover services from either in-network or out-of-network providers, if the services are covered benefits and meet medical necessity criteria.
- When a member uses an out-of-network/non-MA contracted provider, the member's share of the costs for covered services may be higher.
- To see whether specific providers are in network or services are covered the member can call Customer Service or utilize the member portal located at myBlue KCma.com. This provider can help initiate Prior Authorization for any medically necessary services as needed.

INITIAL ORGANIZATIONAL DETERMINATION (OD)

The initial request for services is called an Organizational Determination (OD). These are typically requested by the treating provider on behalf of the member. Whenever a member or treating provider contacts Blue KC to request a service, the request itself indicates that the member believes that Blue KC should provide or pay for the service. Thus, the request constitutes a request for a determination and Blue KC's response to the request constitutes an organization determination.

PEER-TO-PEER CONSULT WITH MEDICAL DIRECTOR

When a Blue KC Medical Director has determined that the medical necessity criteria have not been met, the requesting provider is then notified of an "intent to deny." The requesting physician then has the option to request a peer-to-peer discussion with the Blue KC Medical Director. The attending physician may delegate this responsibility to a non-physician provider (Nurse Practitioner, Physician Assistant, etc.). However, there will not be an opportunity for a second Peer-to-Peer should the outcome of that initial discussion be to uphold the initial decision. The notification of our "intent to deny" will be called to the requesting provider with timelines for completion given and the phone number to call. Providers can also initiate a peer-to-peer discussion by contacting the plan's utilization case manager for your facility.

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 health care 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 health care setting/level of care and/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 KC provides an appeal process for members in the event of an adverse determination.

Adverse organizational determinations of requested services are communicated telephonically or via fax to the requestor within one (1) business day from when the determination was made. This communication is confirmed in writing via the Integrated Denial Notice (IDN) within three (3) days of the oral communication. This notification is sent to the member 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. A Blue Medicare Advantage member must receive this determination within 14 days of service request unless an expedited determination is necessary. Other levels of the members' appeal process are addressed in the Blue Medicare Advantage Evidence of Coverage.

MEMBER APPEALS

A member appeal is the type of request a member (or authorized representative) makes when the member wants Blue Medicare Advantage to reconsider and change an initial coverage/organization determination (by Blue Medicare Advantage or a provider) about what services, benefits or prescription drugs are necessary or covered or whether Blue Medicare Advantage will reimburse for a service, a benefit or a prescription drug. An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Blue Medicare Advantage denies it, the member has the right to appeal. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Blue Medicare Advantage or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Blue Medicare Advantage concerning reimbursement for a health care service.
- An adverse initial organization determination by Blue Medicare Advantage concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service

All details around how and where to submit an appeal are provided in the denial letter sent to the member, requesting provider and hospital (where applicable).

All Medicare member concerns that do not involve a reconsideration of a service or medical drug denial may be considered grievances and are addressed through the grievance process.

PARTICIPATING PROVIDER RESPONSIBILITIES IN THE MEMBER APPEALS PROCESS

Physicians can request standard or expedited appeals on behalf of their members; However, if not requested specifically by the attending physician, an Appointment of Representative Form to submit an appeal on behalf of a Medicare member, may be required. The Appointment of Representative Form can be found online and downloaded here: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207

- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process.

Appeal time frames

- Members or their authorized representatives have 60 days from the date of the denial of service to file an appeal. The 60-day filing deadline may be extended where good cause can be shown.

- For standard service appeals, service and payment issues must be resolved within 30 calendar days from the date the request was received.
    - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals generally are resolved within 72 hours, unless it is in the member's interest to extend this time period.

  - For payment appeals, service and payment issues must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.

- 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 KC must resolve an expedited review within seventy-two (72) hours or as expeditiously as the member's physical or mental health requires once complete documentation has been received by the Plan. An expedited appeal can be made by the member or provider on behalf of the member.

Further Appeal Rights: If Blue Medicare Advantage is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- Blue Medicare Advantage will forward the appeal to an Independent Review Entity (IRE) contracted with the federal government.
- The IRE will review the appeal and make a decision:
  - Within 72 hours if expedited.
  - Within 30 days if the appeal is related to authorization for health care.
  - Within 60 days if the appeal involves reimbursement for care.
  - If the IRE issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).
  - If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

HEALTH RISK APPRAISALS

Blue KC sends a Health Risk Appraisal (HRA) to each member upon confirmation of the member's effective date from CMS, and annually thereafter. These HRAs are analyzed in order to identify those members who have complex or serious medical conditions. The information gathered through the HRA is forwarded to the primary care physician for inclusion in the member's record. The primary care physician 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 KC pays the enrollee the difference between original Medicare cost-sharing incurred for qualified clinical trial items and services and Blue KC'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 KC and continue to get the rest of their care that is unrelated to the clinical trial through Blue KC. In addition, if plan guidelines are followed, a member may be made whole financially for the difference between original Medicare's member cost share and their Blue Medicare Advantage cost share for identical benefits. 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 member that you intend to refer for a clinical trial, notify the Utilization 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.

NEVER EVENTS

It is the policy of Blue KC Medicare Advantage not to pay for care resulting in a Never Event. The National Quality Forum defines "Never Events" as errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients. Included in the list of Never Events as a Surgical Event, is surgery performed on the wrong patient. "Never events," like surgery on the wrong body part or mismatched blood transfusion, cause serious injury or death to beneficiaries, and result in increased costs to the Medicare program to treat the consequences of the error.

Never events are characterized as:

- Unambiguous - clearly identifiable and measurable, and thus feasible to include in a reporting system;
- Usually preventable - recognizing that some events are not always avoidable, given the complexity of health care;
- Serious - resulting in death or loss of a body part, disability, or more than transient loss of a body function; and
- Any of the following:
    - Adverse and/or,
    - Indicative of a problem in a health care facility's safety systems and/or,
    - Important for public credibility or public accountability.

For a list of specific events included in this index, refer to cms.gov.

BEHAVIORAL HEALTH SERVICES

Blue KC has contracted with New Directions Behavioral Health (NDBH) for the provision of mental health services. To arrange for care, a physician or member may call NDBH at the number noted in the Plan Information Contact List section (page 6). Prior authorization is required for inpatient admissions.

Member has direct access and must be seen by a provider contracted for Blue Medicare Advantage to receive covered services.

The New Directions Behavioral Health team of mental health professionals is available 24 hours a day, seven days a week. Participating providers include:

- Professional Counselors and Psychologists
- Psychiatrists
- Psychiatric nurses and Social Workers
- Facilities for inpatient and outpatient care including rehabilitation

Instructions for claims routing and submission are listed in the Plan Information Contact List (page 6) located in the front of this manual.

PHARMACY BENEFIT MANAGEMENT

Pharmacy Network

This section covers Pharmacy Benefit Management for all members who receive their Pharmacy Benefits through the Blue Medicare Advantage contracted Pharmacy Benefit Manager (PBM).

In some instances, Employer Groups may contract Pharmacy Benefits directly with a different PBM. Refer to the Member ID card for Pharmacy Benefit Contact Information.

Blue Medicare Advantage provides coverage for prescription medications and members may have their prescriptions filled through a wide network of pharmacies, including mail order. For contact information (see Plan Information Contact List section-page 6).

Refer your Blue Medicare Advantage patients to the Blue Medicare Advantage provider directory for a comprehensive list of participating pharmacies.

Medicare Part D Formulary

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

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 Medicare Advantage members:

- Drugs used for anorexia, weight loss, or weight gain;
- 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); and
- Inpatient drugs.

Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Blue Medicare 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

The Blue Medicare Advantage Part D formulary is organized into five (5) drug tiers.

Tier 1 - Preferred Generic Tier 2 - Generic Tier 3 - Preferred Brand Tier 4 - Non-Preferred Drug Tier 5 - Specialty	• Members pay a copayment for drugs in Tiers 1 through 4, and co-insurance for drugs in Tier 5. • In general, the lower the drug tier the lower the member's cost share.

There are four coverage phases under the Medicare Part D benefit – Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

During the Deductible Phase, a member pays 100% of the cost of the services up to a maximum amount. Once the member has reached the deductible limit, the member cost shares will be defined by the Initial Coverage Phase. Blue KC does not currently have any plans with a Part D Deductible phase.

During the Initial Coverage Phase, a member pays part of the cost (copayment or coinsurance) of a covered Part D drug and Blue Medicare Advantage pays the remainder. The member remains in the Initial Coverage Phase until the individual's total drug costs (amount member pays plus the amount Blue Medicare Advantage pays) reaches the CMS defined Drug cost limit. This is also known as the Initial Coverage Limit, or the "ICL". CMS establishes an ICL dollar amount, annually, but allows Medicare Advantage plans to offer an enhanced benefit that expands the Initial Coverage Phase. Currently Blue KC plans follow the CMS defined drug cost limit but do have varying cost shares based on the plan in which the member is enrolled.

Once a member has reached the ICL, the individual moves into what is called the Coverage Gap Phase, also known as the "donut hole". Once a member is in the Coverage Gap Phase, the member must pay 25% of his or her prescription drug costs before catastrophic coverage begins. Members receive a discount off the cost of brand drugs while in the coverage gap; the amount of the discount is predetermined by CMS each year and is currently at 70%. Members remain in the Coverage Gap Phase until they have paid a True-Out-Of-Pocket amount (TrOOP amount) equal to a pre-determined dollar amount as established annually by CMS. This TrOOP amount includes both the member paid amounts as well as the 70% manufacturer discount on brand drugs. Currently Blue KC plans follow the CMS defined TrOOP limit but may have varying cost shares based on the plan in which the member is enrolled.

Once a member reaches the TrOOP amount; the member moves into the Catastrophic Coverage Phase. In the Catastrophic Coverage Phase, members are responsible for paying the greater of a small copayment or coinsurance, as established annually by CMS, for covered Part D drugs and Blue Medicare Advantage pays the remainder of the drug cost. Blue KC follows CMS guidelines for this phase in all individual plans.

Medicare Covered Prescription Drugs (also called Medicare Part "B" Drugs)

Prescription drugs that are covered under Original Medicare are also covered for Blue Medicare Advantage members. Prescription drugs include 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 against the member's outpatient prescription drug benefit. Certain Part B drugs require prior authorization from Blue Medicare Advantage.

The following drugs are Medicare covered drugs:

- Drugs that usually are not self-administered by the member and are injected while receiving physician services.
- Blue Medicare Advantage also covers some drugs that are "usually not self-administered' even if the member injects them at home.
- Drugs used with durable medical equipment (such as nebulizers) that are authorized by Blue Medicare 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 and anti-nausea drugs.
- Insulin when administered via an insulin pump.
- Erythropoietin by self-injection if the member has end-stage renal disease, receives home/outpatient dialysis, and needs this drug to treat anemia.

Part D and Part B Prescription Drugs Requiring Prior Authorization

Requests for coverage of prescription drugs are routed differently within the health plan depending on who is furnishing and billing for the prescription drug (i.e. pharmacy vs. medical). Review the information below 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.

Part D Prescription Drugs Furnished and Billed Through Pharmacy – Part D Prescription Drug Coverage Form

Certain Part D drugs are subject to prior authorization, quantity limits or step therapy requirements, as noted in the Blue Medicare Advantage published formulary. Prior authorization and formulary exception requests and requests for coverage of drugs subject to quantity limits or step therapy requirements may be made by calling the Pharmacy contact (see Plan Information Contact List section-page 6) or by faxing or mailing in a request. Requests can be made using the ***Request for Medicare Prescription Drug Coverage Determination*** form. The form is available for download from the Provider Portal under the 'Forms' link or you can call the plan and request that we fax the form to your office. From the Provider Portal you can also access an electronic version of the form which can be securely submitted online. Completed forms should be faxed or mailed to the Part D Prior Authorization Department at the fax number/address located at the top of the form.

Some prescription 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.

Part B Prescription Drugs Furnished and Billed Through Medical Benefit – 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 Utilization Management (see Plan Contact Information List section-page 6). Requests may also be made by completing the ***Part B Drug Prior Authorization Request Form***. Completed forms should be faxed or mailed to Utilization Management at the fax number/address located at the top of the form.

Expedited Time Frames for Prior Authorization Requests

Expedited Prior Authorization requests should be reserved for cases when you are able to attest that the member's health or life could be in jeopardy if the standard timeframe is applied. Please note that for expedited requests for Part D prescription 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. For Part B prescription drugs billed through medical, the expedited timeframe is 72 hours.

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. For Part D drugs, it is helpful to review the PA criteria on the provider portal and submit all of the required information with the request. For Part B drugs billed through medical, the drug-specific PA request form shows 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 Overutilization Monitoring Program

The Centers for Medicare & Medicaid Services (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. For more information about the Blue Medicare Advantage opioid overutilization monitoring program, refer to Providers.BlueKC.com under **RESOURCES - Medicare Advantage Reference Guide tab**.

Part D Payment for Prescription Drugs for Beneficiaries Enrolled in Hospice

The Centers for Medicare & Medicaid Services (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 prescription 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 prescription 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 prescription drug to pay under Part D. Otherwise members will be directed to obtain the medicine from the hospice provider.

Payment for Prescription Drugs for Beneficiaries with ESRD

The Centers for Medicare & Medicaid Services (CMS) requires that Part D sponsors utilize 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. For the seven categories of prescription drugs that are considered by CMS to be sometimes related to ESRD, a prior authorization will be required to determine whether the drug should pay under Part D or under the ESRD bundled payment.

Medication Therapy Management Program (MTMP)

The Blue Medicare 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 medications 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 medications 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.

CASE MANAGEMENT

As a partner in managing the health needs of our members, Blue KC offers a variety of case management services that are available through referral by their primary care physician, providers, 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 a health outreach specialist, nurse case managers, social workers, and clinical pharmacists.

Reasons for referral include, but are not limited to:

- Medical concerns regarding an acute and or chronic disease process
- Behavioral health concerns
- Social or financial stressors
- Post-hospitalization care
- Existing service need
- Compliance issue (Non-Adherent with Medications or with Physician Treatment Plan)

To make a referral, simply call customer service at (866) 508-7140 and explain your needs. The customer service representative will secure relevant/needed information and forward to our Case Management Department where the request will be triaged and assigned. Primary care physicians will receive notification and discontinuation of care management services.

QUALITY IMPROVEMENT INITIATIVES

The Chronic Care Improvement Program (CCIP) program focused on the promotion of effective management of chronic diseases. Effective management of chronic conditions is expected to result in slowing of the disease progression, prevention of complications and development of comorbidities, preventable emergency room visits and inpatient stays, improved quality of life for the member and cost savings to the plan, provider and member. CCIP should improve member health outcomes, improve satisfaction and have measurable outcomes.

The Quality Improvement Program (QIP) is a program to improve health outcomes and or member satisfaction and address one or more of the CMS Quality Strategy Goals which have yet to be identified by CMS.

EMERGENT/URGENT CARE

Emergency Care

Blue KC advises members to go to the nearest hospital emergency room if they believe that 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 Utilization Management Department **must** be notified of a hospital admission within 48 hours. If an admission through the emergency room is made by a doctor other than the primary care physician, the primary care physician 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/Urgently Needed Care

Urgently needed 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 primary care physicians or other plan providers. Members (or their authorized representatives) are instructed to contact their primary care physicians as soon as possible. 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 Utilization Management Department.

Non-Participating Hospitalization

Whenever we are advised that a Blue Medicare Advantage member has been hospitalized on an emergency basis in a non-participating facility, we will notify the member's primary care physician. If the member calls the primary care physician, the primary care physician is required to notify Blue KC within 48 hours. The member should be transferred to a Blue Medicare Advantage participating facility when the member's condition has stabilized. These transfer services require authorization by the Utilization Management Department.

DIALYSIS PATIENTS

For those patients who initiate hemodialysis for ESRD, 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 projectcrownweb.org/.

MEMBERS THAT RESIDE IN LONG-TERM CARE

When a member needs long term custodial care, the individual and his or her family can choose any facility within our service area. Note that the member is going to that facility in a private pay capacity as neither Blue KC nor traditional Medicare cover the cost of custodial care. Blue KC needs to be informed of this action either by the member, a family member or the primary care physician. The individual can remain a member of the plan; however, the member must continue to abide by plan rules for any care that he or she requires while living in the facility. Such care must be directed by an in-network primary care physician and in-network providers must be utilized to receive most covered services.

The primary care physician has various options to manage a custodial patient, which include:

- If practical, the member can continue to be seen in the primary care physician's office.
- The primary care physician can continue to see and treat the member in the facility.
- The primary care physician can communicate to the Medical Director of the facility and request that the facility medical director oversee the member's care on behalf of the primary care physician. Good communication needs to be established between the primary care physician and the Medical Director for the continuation of coordinated care.

NEW TECHNOLOGIES

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

Blue KC also has a process for accepting requests from physicians 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 KC will determine if the new treatment or procedure is a covered benefit.

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

Requests for coverage of a new or emerging technology (all CPT codes ending in "T") should be submitted in writing, prior to providing or securing the service, to Provider Correspondence. The address and fax number are located in the Plan Information Contact List section (page 6).

OUTPATIENT LABORATORY TESTS

All network providers must send specimens to Quest Diagnostic and LabCorp lab facilities identified in our Provider Directory. (The list of Outpatient Lab tests that can be performed in a PCP, specialist or urgent care office without sending to Quest or LabCorp can be found on the Providers.BlueKC.com under **RESOURCES - Medicare Advantage Reference Guide tab**).

CLAIMS SUBMISSION

Claims must be submitted using standard Medicare guidelines. Blue Medicare Advantage accepts CMS 1500 or UB-04's and electronically submitted claims. Refer to the Electronic Claims section for further information.

Contracted providers should seek electronic claims solutions as indicated in their Health Plan contract. **If the provider must bill on paper, they should follow standard CMS claims submission requirements including submission of the Blue Medicare Advantage Member ID as it appears on the member ID card.**

The provider is responsible for ensuring accurate and complete data for submission. The provider is also responsible for any request made on their behalf by the staff personnel. Claims are not accepted via fax. When filing claims for secondary coverage, be sure to include the Explanation of Benefits from the primary insurer or the claim will be denied.

Blue Medicare Advantage processes all clean claims within the 30-day CMS required standards. Status checks can be performed via our Provider Portal. Blue Medicare Advantage permits submission of claims for up to 6 months from the date of service per provider contract.

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

- Routine eye exams and eyewear to EyeMed Insight (only applicable to providers in the EyeMed Insight Network)
- Routine Hearing Exams and Hearing Aids to TruHearing (only applicable to providers in the TruHearing Network)
- Routine dental services to DentaQuest (only applicable to providers in the DentaQuest Network)

Contact information for the above vendors is located in the Plan Information Contact List section (page 7) of this manual.

Refer to the following table for guidelines around which claim form to use by reimbursement type:

Reimbursement type	***Reimbursement***	***Claim Form***
Inpatient Hospital	IPPS	UB-04
Inpatient Part B Hospital	OPPS	UB-04
Outpatient Hospital	OPPS	UB-04
Long Term Acute Care Hospital	LTAC PPS	UB-04
Inpatient Psychiatric Hospital	IPS PPS	UB-04
Inpatient Rehab Hospital	IRF PPS	UB-04

Inpatient Skilled Nursing Facility	SNF PPS	UB-04
Inpatient Part B Skilled Nursing Facility	MPFS	UB-04
Outpatient Skilled Nursing Facility	MPFS	UB-04
Home Health Agency - RAP Claim	HH PPS	UB-04
Home Health Agency - Reconciliation Claim	HH PPS	UB-04
Home Health Agency - LUPA Claim	HH PPS	UB-04
Dialysis - ESRD	ESRD PPS	UB-04
Hospice	Medicare FFS - Carved out from MA Plans	UB-04
Rural Health Clinic (RHC)	Facility specific Rate	UB-04
Federally Qualified Health Center (FQHC)	FQHC PPS	UB-04
Critical Access Hospital (CAH) - Inpatient	Facility specific Rate	UB-04
Critical Access Hospital (CAH) - Outpatient	Facility specific Rate	UB-04
Durable Medical Equipment	DME Fee Schedule	CMS-1500
Para-Enteral Nutrition Supplies	PEN Fee Schedule	CMS-1500
Clinical Laboratory	Clinical Lab Fee Schedule	CMS-1500
Hospital/CAH acting as reference Lab	Clinical Lab Fee Schedule	UB-04
Ambulatory Surgery Center	ASC Fee schedule	CMS-1500
Ambulance	Ambulance Fee Schedule	CMS-1500
Anesthesia	Medicare Physician Fee Schedule for per-unit rate	CMS-1500
Anesthesia - Nurse Anesthetist	Medicare Physician Fee Schedule for per-unit rate	CMS-1500
Professional Services - non-Facility Rates	Medicare Physician Fee Schedule	CMS-1500
Professional Services - Facility Rates	Medicare Physician Fee Schedule	CMS-1500

Professional Services - Nurse Practitioner, Physician's Assistant	85% of Medicare Physician Fee Schedule	CMS-1500
Part B Drugs	Part B Drug Fee Schedule	CMS-1500
Clinical Lab Fee Schedule - Gap Fill	Gap Fill Fee Schedule	CMS-1500
Occupational Therapy/Physical Therapy Assistants (OTA/PTA)	Medicare Physician Fee Schedule	CMS-1500

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 as well as decreasing the turnaround time for claims payment.

All Electronic claims must be routed to Administrative Services of Kansas (ASK) for all Blue KC lines of business.

- ASK accepts electronic claims directly or through a clearinghouse.
- After a claim file has been submitted to ASK a Claims Acknowledgement (277CA) is produced which indicates if each claim was accepted or rejected for various claim edits.
- If a claim was rejected, it must be corrected and resubmitted.
- Only accepted claims are transmitted for processing.

If you have questions or issues with the submission of your electronic claims, contact the ASK Help Desk at 800-472-6481.

PROPER SUBMISSION OF PROVIDER ID'S

Since Blue Medicare Advantage is a Medicare Advantage Plan, we follow Medicare billing guidelines.

To ensure payment is issued to the correct provider of service, here are claims submission tips:

All physician services require identification of the ordering/referring and rendering provider's NPI and taxonomy.
This includes all services from all physician extenders such as Nurse Practitioners and Physician Assistants, even if they require supervising physician's NPI and identification.

Electronic Claim Submission
Send your Type I and Type II NPI(s) and taxonomies as you do for all other Blue KC lines of business.

Provider ID's via paper claims
Send your Type I and Type II NPI(s) and taxonomies as you do for all other Blue KC lines of business.

TIMELY FILING REQUIREMENTS

Providers must adhere to the following timeline filing requirements:

	Initial Claim	**Adjustment/ Review/ Determination**	**Appeal**
Participating/ In-Network/ Blue Medicare Advantage contracted	180 days from date of service	365 days From date of service	Not allowed unless it involves a pre-service request
Non-Participating/ Out of Network/ not Blue Medicare Advantage contracted	12 months from date of service	365 days from date claim processed	365 days From initial organizational determination

DEFINING PLAN TERMS

Claim resubmission

A claim is processed by Blue Medicare Advantage and 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 for services prior to January 1, 2018).

If no payment was issued on the claim line in question the claim can be resubmitted on paper or electronically, but 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.

If an amount was paid on the claim line in question, the provider should not use the claim resubmission process. See Corrected Claims options below.

CORRECTED CLAIMS

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 done within the timeframes outlined in the individual provider contract.

Examples of a corrected claim submission include:

- Adding or removing a previously paid claim line that is the result of charges billed for a service that ended up not being rendered or not billed for a service that was rendered.
- Changing a previously paid claim line that is the result of incorrect dates of service or incorrect procedure code billed.

Note: All requests must be submitted as corrected claims.

All corrected claims must be clearly indicated as a correction as follows:

- **All Corrected Electronic Claims-** Follow these instructions:

Name of Data Element	837P Loop and Data Element	Data Element Information
Claim Frequency Type Code	2300/CLM05-3	7 (Replacement of a Prior Claim)
Payer Claim Control Number Qualifier (Original Reference Number Qualifier)	2300/REF01	F8
Payer Claim Control Number (Original Claim Number)	2300/REF02	The original BCBSKC assigned claim number.
Claim Note Reference Code	2300/NTE01	ADD (Additional Information)
Claim Note Text	2300/NTE02	Free-form text field (80 characters) to provide a description of correction. Entering "Corrected Claim" is not acceptable.

- **CMS 1500 Claim Forms:** The paper 1500 claim submitted must indicate a Frequency of 7 in Box 22 (Resubmission Code Box) and the Original Reference Claim Number in Box 22 (Original Ref. No. Box). The claim form should reflect a clear indication as to what has been changed. All previous line items must be submitted on the corrected claim.
- **UB Claims Forms:** UB04 paper claim forms submitted as corrected claims can also be submitted on paper. The paper UB04 claim submitted must indicate a Frequency of 7 in field 4, the Original Reference Claim Number in field 64 and a reason for the correction in field 80.

A corrected claim will not be accepted after an official overpayment notice has been sent to the provider outlining the reason for the recoupment and dispute process.

PROVIDER PAY DISPUTES

Per contract definition, a dispute occurs when the Plan has made payment on a claim or line, but the contracted provider disagrees with the amount that has been paid. Again, the timeframe is defined in the provider's individual contract, but in general is permitted if brought to our attention within twelve (12) months from when the initial claim was paid. In no case may participating 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. Send your written claims dispute requests with all supporting documentation to Blue Medicare Advantage Correspondence. The address is located in the Plan Information Contact List section (page 6).

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

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

- **Electronically:** The only proof Blue Medicare Advantage will accept as timely filing is the Administrative Services of Kansas ASK 277CA report showing the claim was accepted for processing.

- **Paper:** The provider must submit supporting documentation from their practice management system including the applicable field descriptions since the documentation is specific to your system OR a UB04, CMS 1500 with the original date billed AND documentation must support the claim being submitted within twelve (12) months from the date of service, AND follow-up done at a minimum of every sixty (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.

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

CLAIM APPEALS

Appeals do not apply to participating providers unless it involves a pre-service request.

All appeals must be submitted in writing.

A claim appeal can be filed by either a member or a non-participating provider. Appeals must be filed in writing within 365 days from the date of the initial organizational determination (i.e., EOB is issued or provider remit, whichever is applicable).

Any non-participating 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-participating appeal requests and is also available on our website.

RE-OPENINGS

A re-opening is generally used by the Plan if a clerical error is discovered. The Plan proactively reprocesses claims based on that finding. For example, Blue KC finds they 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 correct payment.

A re-opening may be initiated by a participating provider if the situation does not fall under one of the before mentioned categories (i.e., Mod 22 is billed, and provider is expecting additional payment). This is not a contract dispute issue and the Plan did not pay additional monies. Provider must submit their request for a re-opening in writing.

If a denial occurred as the result of a Plan 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.

MEMBER COPAYMENTS AND/OR COINSURANCE

Copayments
It is the provider's responsibility to collect applicable copayments from members at the time of service.

Coinsurance
Blue Medicare 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 Medicare Advantage makes payment on the claim. The remittance advice will indicate the member's liability to be billed by your office.

Maximum Out of Pocket (MOOP)
Maximum out of pocket, is the maximum a member pays out-of-pocket for medical (not Part D drugs) covered services within a calendar year.

Balance Billing
The term "balance bill" refers to billing a member above an approved and/or contracted amount for a covered and payable service or billing a member for a service Blue Medicare Advantage denied. Blue Medicare Advantage members cannot be "balance billed" except for copayments, coinsurance and/or deductibles, in most cases, whether you are a contracted Blue Medicare Advantage provider or not. Blue Medicare Advantage members are protected under Medicare balance bill guidelines. They are held harmless for payment beyond their plan cost share (i.e., deductible, copayment, or coinsurance). The member's EOB, "Your Share" and the providers 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 a claim is denied for administrative reasons (e.g., 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. Refer to our claims timely filing policy found under Billing Guidelines (page 58).

Qualified Medicare Beneficiary (QMB) Program
The Qualified Medicare Beneficiary (QMB) Program helps low-income Medicare beneficiaries pay Medicare Part A & Part B premiums and cost-sharing, like deductibles, copays, and co-insurances. Medicare members who are also enrolled in their state Medicaid program and who meet certain income requirements. Because eligibility is tied to income requirements, members' eligibility for the program can vary throughout the year.

Provider responsibility:
All Plan providers (even those that do not accept Medicaid) are prohibited under federal law from billing members in the QMB Program for their cost-share of covered Parts A and B services, including Part B-covered prescription drugs.
Important points to remember:

- If a provider has erroneously billed a Plan member who is also QMB-eligible, recall the charges and refund the member.
- All Plan providers can seek payment for Medicare cost-sharing for QMB-eligible members from the member's state Medicaid program.
- Consult the applicable state Medicaid program for information on billing processes that apply to seeking payment from Medicaid.
- If a QMB-eligible member receives a statutorily excluded service from a provider that Medicare never covers, the provider could bill the member for the full cost of care. However, if the Medicaid program covers the service AND the provider participates in Medicaid, Medicaid coverage may be available for the service.

For more information on the QMB program, please contact your state Medicaid program or go to CMS or refer to CMS website for additional details.

ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)

ABNs are not applicable to members in Blue Medicare Advantage 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 KC if they know or have reason to know that a service may not be covered by Medicare.
- If Blue KC denies the coverage request, an Integrated Notice of Denial (IDN) will be issued to the member and requesting provider.
- After the member is notified of denial via the IDN and prior services being rendered, the provider may collect fees from the member for the specific services outlined in the IDN, should the member desire to have the non-covered services performed.

GENERAL BILLING/REIMBURSEMENT GUIDELINES

Blue KC pays Medicare Advantage claims using CMS payment methodologies, unless otherwise contractually specified, and CMS NCCI, MUE, add-on, OCE and NCD/LCD edits to include but not limited to:

Multiple Surgeries

Payment guidelines for a facility for multiple surgical procedures when performed at the same operative session as denoted in your provider contract are as follows:

- 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 25% of fee schedule minus copayments, deductibles, as applicable.

Payment guidelines for physician/practitioner multiple surgical procedures when performed at the same operative session as denoted in your provider contract are as follows:

- 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, deductibles, as applicable.

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

Assistant Surgeons

Payment guidelines for assistant surgeons – assuming that an assistant surgeon is warranted based upon the surgery performed – are as follows:

- For MD's, 15% of total amount paid to the surgeon minus copayments and deductibles, as applicable;
- For PA, nurse practitioner, and clinical nurse specialist, reimbursement is limited to 85% of the surgeon's allowable minus any copayments, deductibles, as applicable;
- Multiple surgery restrictions apply.

Informed Consent for Sterilization

Blue KC reminds providers of their responsibility in compliance with 42 CFR part 50, subpart B to obtain informed consent for certain sterilization procedures and to retain that documentation on file in the patient's medical record. You may find standardized consent forms at https://opa.hhs.gov/sites/default/files/2020-07/consent-for-sterilization-english-updated.pdf. For a full overview of the rule, please access https://opa.hhs.gov/sites/default/files/2020-07/42-cfr-50-c_0.pdf.

Welcome to Medicare Visit/Preventive Physical Examination (IPPE)/Annual Wellness Visit (AWV)/Personalized Prevention Plan of Service (PPPS)/Routine Physical Exam

The following contains Blue Medicare Advantage information regarding these services.

Service Description	Frequency	Payment	HCPCS or CPT Code
Welcome to Medicare Visit / Initial Preventive Physical Examination (IPPE)	1 / lifetime within the first 12 months of Medicare Part B coverage	$0 copayment or coinsurance*	**G0402**
Annual Wellness Visit (AWV) / Personalized Prevention Plan of Service (PPPS)	1 / calendar year after the first 12 months of Medicare Part B coverage	$0 copayment or coinsurance*	**G0438** (first visit) **G0439** (subsequent visits)

***If you also bill other services with these visits and these services are normally subject to a copayment or coinsurance that copayment or coinsurance will still apply even if the primary reason for the visit was the IPPE or AWV/PPPS. Benefits, premium and/or copayments/coinsurance may change on January 1 of each year.

Members may receive an IPPE or AWV/PPPS and a routine physical exam on the same day from the same primary care physician as long as all components of both are provided and documented in the medical record. **For employer groups Benefit contingent on plan design.**

Service Description	Frequency	Payment	Description by age and patient type	HCPCS or CPT Code
Routine Physical Exams	1 / calendar year	Reimbursement rates per contract*	new patient; age 18-39	99385
			new patient; age 40-64	99386
			new patient; age 65+	99387
			established patient; age 18-39	99395
			established patient; age 40-64	99396
			established patient; age 65+	99397

For more information about the IPPE, refer to "The ABCs of the Initial Preventive Physical Examination (IPPE)" at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243320.html on the Centers for Medicare & Medicaid Services (CMS) website.

For more information about the AWV, refer to "The ABCs of the Annual Wellness Visit (AWV)" at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/AWV_chart_ICN905706.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Technical Component (TC) vs. 26 Pricing

Based on standard contract language, be aware of how the allowable is determined for procedures that contain both a technical and professional component. Most contracts limit the additional payment amount (i.e., 100% of Medicare's allowable) to the professional component only. That means if a charge of CPT 71020 (with no modifier) is received, the claim will process at the global procedure (both TC and 26 components) and your contracted rate is 100% of the Medicare fee schedule, the Blue Medicare Advantage allowable is determined by 100% of the Medicare fee schedule assigned to 71020TC + 100% of the Medicare allowable assigned to 7102026.

Multiple Imaging Procedure TC/PC Discounting

Multiple imaging procedure discounting rules apply when all of the following are true:

- Multiple imaging procedures are provided
    - By the same provider
    - For the same patient
    - On the same date of service
- Modifier 59 and 78 are not present

This logic applies to multiple codes or multiple units. The imaging procedure with the highest fee schedule rate will be paid at 100% of the technical component rate and 100% of the professional component rate. All other imaging procedures will be paid 50% of the technical component rate and 95% of the professional component rate. Procedures subject to these rules are flagged in the MPFS with a multiple procedure payment reduction (MPPR) indicator of "4".

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.

Physician Extender (Nurse Practitioners, Physician Assistants)

Services rendered by a physician extender such as a Nurse Practitioner or Physician Assistant will be paid at 85% of fee schedule.

CLIA Number on Claims

Reimbursement for all labs must have the CLIA number submitted on the claim in the claim in box 23 of the CMS-1500.

Mammography FDA License Number

Reimbursement for all mammography imaging services must have the FDA number submitted on the claim in box 23 of the CMS-1500.

Part B Drugs – Classified and Not Otherwise Classified* (NOC) Drugs

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

- The name of the drug

- The total dosage (plus strength of dosage, if appropriate)
- The method of administration
- The 11-digit NDC Code (National Drug Code)

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

Fraud and Abuse

What Constitutes Fraud, Waste and Abuse?

Fraud, Waste and Abuse (FWA) encompasses a wide range of improper billing practices. Blue Medicare Advantage is committed to identifying, investigating, correcting; and if necessary, referring to law enforcement officials, cases of suspected fraud, waste and abuse by either providers, pharmacies or members.

The definitions of Fraud, Waste and Abuse herein are for reference only and may be subject to change depending upon applicable contract requirements and/or law, including without limitation, case law, statutes, regulations or administrative determinations. If Provider suspects frauds, abuse or misconduct, Provider shall report this information immediately to Blue Medicare Advantage.

Definitions of Fraud, Waste and Abuse

- Fraud: In general, means knowing and willful deception, misrepresentation or a reckless disregard of the facts with the intent to receive an unauthorized benefit.
- Waste: The expenditure, consumption, mismanagement, use of resources, practice of inefficient or ineffective procedures, systems and/or controls to the detriment or potential detriment of entities.
- Abuse: Practices, which, while not necessarily meeting the legal definition of "fraud," conflicted with or take advantage of legally sanctioned standards or contract provisions.

Fraud generally involves a willful act. Waste is generally not considered criminally negligent action but rather a misuse of resources. Abuse involves actions that are inconsistent with acceptable fiscal, business or medical practices.

Fraudulent or abusive practices include, but are not limited to, the following:

- Billing for services not actually performed.
- Falsifying a member's diagnosis to justify tests, surgeries or procedures that aren't medically necessary.
- Misrepresenting procedures performed to obtain payment for non-covered services, such as cosmetic surgery.
- Upcoding – billing for a more expensive service than the one performed.
- Unbundling – billing separately for services that are typically billed together.
- Accepting kickbacks for patient referrals.
- Waiving member co-pays or deductibles and over-billing the insurance carrier or benefit plan.
- Billing a member more than the deductible, co-pay and coinsurance amounts for services.
- Some examples of consumer healthcare fraud are:
  - Visiting numerous doctors ("doctor shopping") to get multiple prescriptions for the same drug is illegal in most states, including Missouri and Kansas.
  - Filing claims for services or medications not received.
  - Forging or altering bills or receipts.
  - Using someone else's coverage or insurance card.
  - Allowing someone else to use a member's insurance card.

Applicable Laws

In providing covered services under the Provider Agreement, Provider must comply with all local, state or federal laws to conduct business and perform obligations. Any provision set forth in the BAA, MA Addendum and State Law Addendum takes priority over conflicts in the Provider Agreement.

The Provider shall not discriminate against a member on the basis of his or her source, method or rate of payment, his or her coverage under a Benefit Plan, age, sex or gender, sexual orientation or preference, marital status, race, color, ancestry, ethnicity, national origin, religion, veteran status, disability, handicap, health status or medical condition (including mental as well as physical), genetic condition, claims experience, evidence of insurability (including conditions arising from domestic violence), utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the member's filing of any complaint, grievance or legal action against the Provider. If Provider suspects frauds, abuse or misconduct, Provider shall report this information immediately to Blue Medicare Advantage.

The following information provides an overview of certain laws that apply to providers.

The Civil False Claims Act

Prohibits:
- Presenting a false claim for payment or approval.
- Making or using a false record or statement in support of a false claim.
- Conspiring to violate the False Claims Act.
- Falsely certifying the type/amount of property to be used by the Government.
- Certifying receipt of property without knowing if it's true.
- Buying property from an unauthorized Government officer.
- Knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay the Government.

31 United States Code § 3729-3733

Penalties: The damages may be tripled. Civil Money Penalty between $10,957 to $21,916 per claim submitted in violation of the False Claim Act.

The Anti-Kickback Statute

Prohibits: Knowingly and willfully soliciting, receiving, offering or paying remuneration (including any kickback, bribe or rebate) for referrals for services that are paid in whole or in part under a federal healthcare program (which includes the Medicare program).

42 United States Code §1320a-7b(b)

Penalties: Shall be guilty of a felony and upon conviction, fines, jail terms and exclusion from participation in federal healthcare programs; $50,000 per kickback plus 3 times the amount of remuneration.

The Stark Statue (Provider Self-Referral Law)

Prohibits: A Provider from making a referral for certain designated health services to an entity in which the Provider (or a member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement (exceptions apply).

42 United States Code §1395nn

Penalties: Up to a $15,000 fine for each service provided. Up to a $100,000 fine for entering into an arrangement or scheme.

The Whistleblower Protection Act

• Allows employees to stop, report or testify about employer actions that are illegal, unhealthy or violate specific public policies. Protects those who report illegal activity from retaliation.
• The Whistleblower Protection Enhancement Act of 2012 protects federal employees who disclose evidence of waste, fraud or abuse.
• Awards for whistleblowers range between 15 and 25 percent of the funds recovered.

Blue Medicare Advantage Right to Audit

Blue Medicare Advantage is authorized to access, inspect, audit and review all claims and records obtained by participating providers. These audits may consist of, but shall not necessarily be limited to, verification of services reported to Blue Medicare Advantage and medical necessity of services and quality of care provided. Blue Medicare Advantage may recover or offset any amount related to billing code errors. There is no time limitation on recovery or offset in instances of fraud or misrepresentation by the healthcare Provider and the right to recover or offset shall not be affected by termination of this Agreement.

Pre-Payment & Post-Payment Audits

Blue Medicare Advantage conducts pre-payment and post-payment audits of patient records and adjudicated claims to verify compliance with medical and payment policies, American Medical Association (AMA) Guidelines, CMS regulations, including medical necessity, established standards of care, appropriate coding and member benefit certificates. Pre-payment and Post-payment audits can range from a basic encounter audit to determine if the level of care is accurately billed, to a complete audit which thoroughly examines all aspects of the medical record and medical practice to determine if the services billed are supported. Post-payment audits are performed after the service(s) is billed and payments have been received by the Provider. If medical necessity is not supported by the medical record, Blue KC will deny as not medically necessary

Documentation in the medical record must reflect the healthcare services rendered to the patient. The Provider shall maintain medical, financial, accounting and other records and will:

- Provide complete records upon request in accordance with your Physician Network Agreement/Physician Participation Agreement including any incorporated Amendments, which includes but is not necessarily limited to Article 2.10 Maintenance of Records; BCBSKC Access to Records (records to be provided upon request).
- Utilize the Blue Medicare Advantage standards for documentation of medical services. If the records are not received within the timeline indicated in the request letter (typically 30 days):
- A technical denial of the claim may be issued, and the overpayment recovery process initiated.
- The Provider may be placed on pre-payment review status.
- The Provider may be considered in breach of our Agreement and may result in termination of participation (in accordance with Article 2.12 Effect of Refusal to Grant Access to Records of the Physician Network Agreement/ Physician Participation Agreement including any incorporated Amendments).

Medical Records for Pre-Payment & Post-Payment Audits

The Provider shall maintain, in accordance with standard and accepted practices and Blue Medicare Advantage standards, such medical, financial, accounting and other records, in an organized record-keeping system.

The first copy of any records requested by Blue Medicare Advantage, its authorized representatives or agents or any governmental agency shall be provided by the Provider at no cost to the requesting party. Records or copies of records requested by Blue Medicare Advantage shall be provided within the timeframe outlined from the date such request is made; however, records shall be provided on an

expedited basis where necessary for Blue Medicare Advantage to conduct a medical records review on an expedited basis, or in the case of an audit or site visit by Blue Medicare Advantage, such records or copies of records shall be provided at the time of the audit or site visit. Site visits, audits or any other inspection of books and records shall occur during regular business hours.

Documentation of Medical Services for Pre-Payment and Post-Payment Audits

Medical records are expected to contain all elements required in order to file and substantiate a claim for services as well as the appropriate level of care, i.e. evaluation and management services. Documentation must support the procedure code, diagnosis code and the appended modifier, as outlined by the American Medical Association (AMA) and ICD-10-CM Guidelines.

Letters/checklist are not acceptable as documentation of medical necessity and do not replace what should be in the complete medical record. Abbreviations must be those that are generally accepted by your peers and clearly translated to be untestable to the reviewer.

Elements of a complete medical record include but are not limited to:

- Physician orders and/or certifications of medical necessity.
- Patient questionnaires associated with physician services.
- Progress notes of another Provider that are reference in your own note.
- Treatment logs.
- Related professional consultation reports.
- Procedure, lab, x-ray and diagnostic reports.
- Billing Provider notes for billed date of service.

First-Level Dispute

Services denied as a part of the post-pay audit process may be disputed in writing within 30 days of notification of the findings. Written notification of disagreement highlighting specific points for reconsideration should be provided with the dispute. Submit the dispute as instructed in the findings letter containing the determination or outcome of the Post-Payment Audit.

Second-Level Dispute

A Provider may request a second and final dispute in writing within 30 days of notification of the first-level appeal determination. Submit the dispute as instructed in the letter containing the determination of the first-level dispute

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 Medicare Advantage member requires treatment for a work-related illness or injury, ask the member to contact his or her employer to report that condition in accordance with the State Workers' Compensation Law. Claims for your treatment of this member's work-related illness or injury should be billed to the employer or the employer's Workers' Compensation insurer. Blue Medicare Advantage's Certificate of Coverage specifically excludes work-related illnesses and injuries.

If the member's employer or the employer's Workers' Compensation insurer denies reimbursement for your services, you should advise the member of that fact. The member 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 KC's authorization procedures so that if the employee successfully contests the issue, you will be reimbursed.

Coordination of Benefits

When Blue Medicare Advantage is the primary carrier, we will compensate participating providers in accordance with the terms of their Blue Medicare 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 we are the secondary carrier, the provider should first seek payment from the member's primary carrier. For Blue Medicare 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 Medicare 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 Medicare 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 bill the member until the issue is resolved.

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

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. Section 1862 (b) also gives the Medicare program the right of subrogation for any amounts payable to the program under the Act.

Therefore, Blue Medicare Advantage operating a Medicare Advantage contract has the same right of recovery. Blue Medicare 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 Medicare Advantage on a conditional basis which permits us to recoup any payments if/when a settlement is reached.

Adjusted Claims, Additional Payments, Overpayments & Voluntary Refunds

Upon discovery of an incorrectly processed claim, Blue KC 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 '180060E000000' would be '180060E000001'. Facility claims often reflect several "adjustments" due to interim bills.

The 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 the single previous one. So, a '02' adjustment will not consider what was paid on the '00' only what occurred under the '01' claim. Due to this, if a "01" adjustment is created in error and causes an overpayment; you may be required to issue the refund in order for Blue KC to perform a "02" adjustment and issue an additional payment. For 1099 (tax purposes), our records reflect the correct payment amount on that particular account.

If an adjustment results in additional payment, this will appear on the weekly provider remit. Blue KC issues additional payments within thirty (30) days of discovery.

If you discover an overpayment while posting your payments, you are obligated – through your contractual agreement with Blue KC and/or CMS regulations – to issue a voluntary refund. To make a voluntary refund, contact Customer Service (see Plan Information Contact List section -page 6). Your cooperation in making timely refunds for overpayments is appreciated.

If Blue KC discovers an overpayment, our claims recovery process is initiated which will include automatically recovering overpaid funds from the next scheduled remittance until the overpayment is resolved. If the overpayment is not resolved within 45 days, you will receive two requests for payment prior to Blue KC referring the account to collections.

If you disagree an overpayment has occurred, in whole or in part, contact Blue Medicare Advantage Customer Service immediately to initiate a "dispute". During the investigation of the dispute, the overpayment record will be placed on hold to ensure we do not perform an automatic recovery until the dispute is resolved.

If Blue Medicare Advantage sends a letter requesting payment, to ensure your refund is applied to the proper overpayment, a copy of the overpayment letter should be included with your refund. To help avoid recordkeeping complexities (because the funds may be taken from other claim payments/patient accounts), we suggest timely processing of overpayment requests.

Once the file is referred for collection, an additional fee is imposed by the collection agency. Blue Medicare Advantage cannot waive this fee.

Preadmission Diagnostic Services

Diagnostic services including, but not limited to, clinical diagnostic laboratory tests, provided by the admitting hospital within three (3) days prior to and including the date of an inpatient admission are not separately payable, but are included in the inpatient payment. The technical component of those diagnostic services performed by a hospital's wholly owned or wholly operated entities (e.g. physician practices and clinics) are also not separately payable when the Blue Medicare Advantage member is admitted as an inpatient within three (3) days.

Reimbursement When Hospice Has Been Elected

CMS regulations state the provider of service will bill "Original Medicare" for both hospice and non-hospice related services. Once Original Medicare has processed the claim and if (a) plan guidelines were followed (i.e., in-network providers were used and required referrals for dates of service prior to January 1, 2018 or prior authorizations were obtained) and (b) the member's cost share under Blue Medicare Advantage is less than Original Medicare the services must be submitted to Blue KC along with a copy of the remittance notice from original Medicare. Since this will require a paper claims submission, indicate on the claim "hospice coordination payment request". This will allow Blue KC to reimburse the difference in the member cost share amount, thereby lowering the member's out-of-pocket expense. This is especially true once the member has met the maximum out-of-pocket (MOOP) for a given calendar year. Providers may verify both the member's cost share by benefit category, as well as his or her current MOOP balance, on the Provider Portal via the Member Eligibility feature.

Example:

Member is hospitalized three (3) days for a total Medicare allowed amount of $25,000. Medicare pays 80% of the allowed charge or $20,000 leaving a member cost share balance of $5,000. The hospital is in-network with Blue Medicare Advantage and prior authorization was obtained. Based on the Blue Medicare Advantage plan this member is enrolled in, the member cost share is $325.00 per day for days 1-6; therefore, a total of $975.00 is the member's applicable cost share if the member's MOOP has not been met.

In the above example, since their Blue Medicare Advantage benefit cost share ($975.00) is less than the cost share applied by Original Medicare ($5,000) and plan guidelines were followed, Blue KC will

reimburse the facility the difference of $4,025.

If you are a primary care physician with a capitation arrangement, you will still continue to receive your applicable monthly capitation payment, since you will remain responsible for coordination of care when the member follows plan guidelines. In order to be paid for any 'carve outs' within your contract; you will have to follow the direction noted above (i.e., file with Medicare).

CAPITATION

Reporting member Encounters for Primary Care Physicians in Capitated Arrangements

Your agreement with Blue KC stipulates that all member encounters must be reported, regardless of your reimbursement methodology. In addition, state regulatory agencies and CMS require reporting member encounters. For Blue Medicare Advantage members, reporting all member encounters is a requirement.

Submitting encounter information also benefits the physician in two ways:

1. Blue KC develops its capitation tables based on actual member usage. Having accurate encounter information will assist in establishing tables that are fair and reflect true utilization.
2. Reporting member encounters relieves the provider of the burden of sorting.

All member encounters should be submitted to Blue KC monthly by ASCII file on disk or on a claim form using the appropriate format outlined in the claim's submission portion of this manual. Send this information to Blue Medicare Advantage Claims.

Failure to submit encounter information may result in our withholding your capitation payment.

ELECTRONIC PAYMENT AND REMITTANCE

Save time and money by ending the administrative burden of receiving paper remits and paper checks.

Contact your Provider Relations external Provider Representative about the benefits of receiving an Electronic Remittance Advice (ERA/835) and receiving Electronic Funds Transfers (EFT).

Note: If you already are receiving ERA and elect to receive EFT, the paper remit that you have been getting will no longer be sent.

QUALITY IMPROVEMENT SERVICES

PURPOSE OF THE QUALITY MANAGEMENT PROGRAM

The Quality Management (QM) Program is a coordinated, multi-disciplinary 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 member satisfaction.

Blue Medicare Advantage's QM Committee is an interdisciplinary committee that derives its authority from the governing body and is delegated the responsibility to oversee the QM Program. The mission of the QM Committee is to ensure that members receive quality health care and services.

CREDENTIALING

All contracted and/or employed physicians and, in some cases, allied healthcare practitioners and participating on the physician panel, must be credentialed – promoting excellence in medical services delivery. This portion of the QM Program is designed to serve as a guide in the coordination of collecting and reviewing all information that is material to a decision to approve or deny participation status to a practitioner. All contracted physicians, professional practitioners, and health delivery organizations must meet minimum CMS and NCQA credentialing requirements and performance standards. In order to be approved for participation, all practitioners must be in good standing with Medicare and Medicaid and must have not be excluded from or opted out of Medicare.

Independent licensed practitioners who are subject to the credentialing requirements include, but are not limited to, MDs, DOs, DDSs, DMDs, Psychiatrists, Psychologists, Podiatrists, Ophthalmologists, Optometrists, Chiropractors, Midlevel's and other health care professionals who provide services to enrollees and are permitted to practice independently under State law.

Those practitioners who practice exclusively within the inpatient setting such as hospitalists or emergency room Physicians may not be subject to the credentialing requirements.

Provider recredentialing will be completed every three years. Providers failing to complete the recertification process will face termination of their contract with Blue KC.

Blue KC uses the Coalition for Affordable Quality Healthcare ProView, to access provider applications. If you are registered with CAQH, ensure that all information and supporting documents are current and that you have authorized Blue KC to access your application. If you are not registered with CAQH, contact Blue KC's Credentialing department for more information about how to register and complete an application. Prior to the credentialing process, Blue KC requires providers to update their CAQH profile, the NPI registry and the Medicare PECOS enrollment file with the correct and accurate information including all practice locations, hours, services, provider taxonomies, hospital affiliations, etc. All provider information must be accurate, maintained at all times and attested to quarterly.

Blue KC may delegate credentialing authority to participating networks after their credentialing program has been audited in accordance with applicable State and Federal regulations, applicable accrediting body standards, and Blue KC's credentialing guidelines. At least annually, Blue KC conducts an audit of the delegated organization's policies and procedures and the organization's performance under these standards through review of provider files.

Blue KC's Credentialing Committee includes representation from a range of participating providers. The committee has full authority and accountability for all initial credentialing and recredentialing including adverse decisions, standards, policies and procedures and the appeal process.

PEER REVIEW

The Peer Review Committee reports peer review activity to the Quality Management Committee. Peer review activity includes the following:

- Monitor and evaluate the quality of medical services rendered by participating providers to Blue Medicare Advantage members;
- Determine whether a quality of care or service issue exists; and if so,
- Impose Corrective Actions based upon Severity Levels;
- Provide educational feedback to providers.

Suspected quality of care and service issues are referred to the Peer Review Committee from various sources: member complaints, case management, concurrent review nurses, and quality improvement monitoring. The Peer Review Committee will identify trends as well as make recommendations regarding the credentialing status of providers. In the event that a participating provider does not conform to Blue KCs performance and quality of care standards, the Peer Review Committee may recommend removal of provider's practicing privileges in Blue KC networks to the Credentialing Committee. The Credentialing Committee will notify the Peer Review Committee of its final decision and notifies the provider in writing of an adverse decision within ten (10) calendar days of the Committee's decision. The written notice will include a summary of the appeal process and instructions for submitting an appeal to the adverse decision.

PREVENTIVE HEALTH GUIDELINES

Preventive health guidelines are developed through a review of the medical literature and are reviewed annually, or as new information become available. 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.

Service	Criteria for Screening	Recommendations
Cervical Cancer Screening	Sexually active female with an intact cervix	• Screening should begin within three years from onset of first sexual activity and no later than age 21 • Screening should occur every two years • Physician may recommend more frequent intervals if risk factors exist- including abnormal pap test in last three years or immunodeficiency virus infection • Women over age 65, with previous normal pap smears may be able to discontinue testing
Mammography	• All women over age 40 • Patients with high risk family history of breast cancer	• Yearly screening over age 40 • Physician may recommend earlier screening if risk factors exist
Colon Cancer Screening	All patients over age 50	• Annual occult blood testing • Flexible sigmoidoscopy every four years or once every 10 years after a screening colonoscopy. • Colonoscopy every two years if member is at high risk for colon cancer; and once every 10 years (but not within four years of a screening sigmoidoscopy) if the member is not at high risk for colon cancer • Double contrast barium enema every two years if at high risk or every four years can be used instead of a sigmoidoscopy or colonoscopy
Adult Immunizations	• Patients are recommended to receive certain vaccinations based on age. • Other Patients with high risk of infection or of diseases may be immunized for those.	• Annual influenza vaccine for all patients • Pneumococcal vaccine for all immunocompetent or high-risk patients over age 65 • Combined tetanus-diphtheria toxoids boosters every 10 years (Substitute TDAP for one Td booster if less than age 65) • Measles and mumps vaccinations to all patients who have not been previously immunized • Hepatitis B – for all young adults not previously immunized and all other patients with high risk for infection • Hepatitis A- for all patients at high risk for infection • Shingles Vaccine • Aspirin regimen for heart health
Prostate Cancer Screening Exams	All men over age 50 should discuss with their physician	• Annual Digital rectal exam and Prostate Specific Antigen (PSA) tests are examples of screening

Service	Criteria for Screening	Recommendations
Cardiovascular Disease Screening	All asymptomatic Medicare beneficiaries	• In all asymptomatic Medicare beneficiary's cholesterol and other lipid or triglyceride level blood tests should be drawn once every 5 years (i.e., 59 months after the last covered screening tests) • In patients with diabetes or heart disease, cholesterol, and other lipid or triglyceride level blood tests should be drawn at least annually
Bone Mass Measurements	All females over the age of 60	• Patients at risk of losing bone mass or at risk of osteoporosis or all women over 60 should be screened at least every two years
"Welcome to Medicare" Physical Exam	• Initial Screening is a one-time benefit • Patients are limited to 1 routine physical exam every year after the initial screening has been completed	• Annual routine physical exam to include measurement of height, weight, body mass index and blood pressure; visual acuity screen and education, counseling • and referral with respect to covered screening and preventive services • The initial "Welcome to Medicare" physical exam can also include an EKG
Abdominal Aortic Aneurysm (AAA)	Medicare beneficiaries with certain risk factors for AAA	• Once in a lifetime • Ultrasound screening
Human Immunodeficiency Virus (HIV) Screening	Beneficiaries who are at increased risk for HIV infection or pregnant	• Annually for beneficiaries at increased risk • Three times per pregnancy for beneficiaries who are pregnant: 1. When a woman is diagnosed with pregnancy 2. During the third trimester and 3. At labor, if ordered by the woman's clinician

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