Provider Guidebook

Medicare Advantage

Blue Medicare Advantage

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1 INTRODUCTION AND GUIDE TO MEDICARE ADVANTAGE

1.1 Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program. Medicare is a health insurance program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home healthcare, and hospice care. Part B helps pay doctor bills, outpatient hospital care and other medical services not covered by Part A.

1.2 Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible member or spouse has paid Medicare taxes for at least 10 years, is age 65, and is a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients qualify for premium-free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80% of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

1.3 Part B

Medicare Part B pays for many medical services and supplies, including coverage for doctor's bills. Medically necessary services of a doctor are covered no matter where received at home, in the doctor's office, in a clinic, in a nursing home or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by CMS. Part B also covers:

- Outpatient hospital services.
- X-rays and laboratory tests.
- Certain ambulance services.
- DME.
- Services of certain specially qualified, nonphysician practitioners.
- Physical and occupational therapy.
- Speech/language pathology services.
- Partial hospitalization for mental healthcare.
- Intensive outpatient services (IOP) for behavioral health
- Mammograms and Pap tests.
- Home Health care if a beneficiary does not have Part A.

1.4 Medicare Local PPO

The Blue Medicare Advantage (BMA) local PPO plan is a managed care plan in which members pay less out-of-pocket costs when they use providers who are part of the Blue Medicare Advantage PPO network. Local PPOs are available in select counties within a state. CMS allows the Medicare Advantage plan to select the counties they want to participate in. BMA has a contract with the federal government that allows BMA to administer all Medicare benefits. Medicare Advantage PPO members are strongly encouraged, but not required, to select a PCP. MA PPO members are also not required to obtain a referral

for specialty care but should coordinate with their PCP. Blue Medicare Advantage PPO members can use providers both in and out of the network. Prior Authorization is required for some services.

1.5 Managed Care Plan Enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A and B and continue paying Part B premiums.
- Live in the plan's service area.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7, each year, with a January 1 plan effective date.

Special Election Period

CMS has identified several circumstances under which a person may change Medicare options outside of the annual or initial enrollment periods. For example, there is an SEP for individuals who have Medicare Part A and Part B and receive any type of assistance from the Medicaid program. This includes both "full benefit" dual eligible individuals as well as individuals often referred to as "partial duals" who receive cost sharing assistance under Medicaid (e.g., QMB-only, SLMB-only, etc.) and individuals who qualify for low income subsidy, but who do not receive Medicaid benefits.

This SEP begins the month the individual becomes dually-eligible and exists as long as he or she receives Medicaid benefits; however, there are limits in how often it can be used. This SEP allows an individual to enroll in, or disenroll from, an MA plan once per calendar quarter during the first nine months of the year. This SEP can be used once during each of the following time periods:

- January through March,
- April through June, and
- July through September.

It may not be used in the 4th quarter of the year (October through December).

1.6 Effective/Termination Date Coincides with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, BMA is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a Skilled Nursing Facility).

BMA is responsible for inpatient hospital services under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A, are covered by the Medicare Advantage plan beginning on the effective date of enrollment.

If the member's Medicare Advantage coverage terminates while the members is hospitalized, BMA is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

1.7 Hospice Election for Medicare Advantage (MA) Members

Members may elect Medicare hospice coverage if they have a terminal illness and meet the appropriate guidelines. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. It also includes physical care and counseling.

When a Medicare Advantage (MA) member elects to enroll in the Medicare Hospice Program, Original Medicare assumes responsibility for payment of all hospice-related and all non-hospice related services rendered during the election period.

The Medicare Advantage plan is responsible for supplemental services covered under the member's MA plan and coordinates benefits for the original Medicare deductible and coinsurance amounts applied so that it does not exceed the MA plan cost-share amount. CMS released CR6778 to clarify that this change in financial responsibility begins on the day of Hospice Election. Some members may have hospice coverage through their Medicare Advantage plan. Please verify the member's benefits.

The following are submission guidelines for Hospice claims:

Hospice-related Services

- Submit the claim directly to CMS

Nonhospice-related Services

- For Part A services not related to the member's terminal condition, submit the claim to the Medicare Fiscal Intermediary using the condition code 07.
- For Part B services not related to the member's terminal condition, submit the claim to the Medicare Carrier with a "GW" modifier.
- For services rendered for the treatment and management of the terminal illness by an attending physician that is not employed or paid by the hospice provider, submit the claim to the Fiscal Intermediary/Medicare Carrier with a "GV" modifier.

Coordination of Member Cost-Share Amount and Supplemental Benefits

- Submit the claim to the Medicare Advantage Plan with the Original Medicare Explanation of Medicare Benefits (EOMB).

Note: The Blue Medicare Advantage plan will coordinate based on the EOMB in the situation where the MA plan liability if the member cost sharing is less than the MA plan cost-share amount. Please submit the claim with the EOMB for consideration.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320 — Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for members who have elected hospice coverage. The Medicare Benefit Policy Manual Publication 100-02 Chapter 9 Coverage of Hospice Service Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication 100-16 Chapter 4 Benefits and beneficiary Protections Sections 10.22 – 10.4 and the CMS Change Request 8727 dated May 1, 2014, all-outline payment responsibility and billing requirements for services rendered during a hospice election period. This documentation is available online at the CMS website: **cms.gov**.

Quick reference information	
Eligibility, Claim Status, Secure Messaging, single claim entry, online remittance advice and commonly used forms	• **Online:** eligibility, claim status, single claim entry, links to secure messaging, commonly used forms and remit information are all available through Availity Essentials at **Availity.com**. For questions on access and registration, call Availity Client Services at **800-AVAILITY.** Availity Client Services is available Monday through Friday, 8 a.m. to 7 p.m. ET (excluding holidays) to answer your registration questions. • **Phone:** Call the provider service number on the back of the member's ID card

Quick reference information	
Prior Authorization	• **Interactive Care Reviewer** is the preferred method for the submission of prior authorization requests. It offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool). Access ICR under *Authorizations and Referrals* via Availity (**Availity.com**). **Phone: 833-848-8730** — Follow the prompts to identify yourself as a provider and then follow the prompts to connect to the correct PA team. **Fax: 866-959-1537** The following information is required for a PA: • Member ID • Legible name of referring provider • Legible name of individual referred to provider • National provider identifier and/or TIN • Number of visits/services • Date(s) of service • Diagnosis • CPT/HCPCS codes
Claims Submission: (Paper)	**Submit Medicare Advantage individual paper claims to:** P.O. Box 61010 Virginia Beach, VA 23466-1010.
Medicare Advantage Participating Provider Appeals and Disputes	Medicare appeals are determined by the liable party, not by the initiator. Please refer to the denial letter or *Explanation of Payment* (*EOP*) issued to determine the correct appeals process. **Medicare** Participating Provider Standard Appeal: A formal request for review of a previous BMA decision where medical necessity was not established and provider liability was assigned (see original decision letter) for services already rendered. Medicare Complaints, Appeals & Grievances (MCAG) Attention: Medical Necessity Provider Appeals Mailstop: P.O. Box 61010 Virginia Beach, VA 23466-1010. **Medicare Participating Provider Administrative Pleas**: A formal request for review of a previous BMA decision where a determination was made that the participating provider failed to follow

Quick reference information	
	administrative rules and provider liability was assigned (see original decision letter), for services already rendered. **and** **Medicare Provider Payment Disputes** A formal request from a provider contesting the paid amount on a claim which does not include a medical necessity or administrative denial and claims payment determinations have already been rendered. Provider Payment Disputes P.O. Box 61010 Virginia Beach, VA 23466-1010.
EDI (Electronic Data Interchange) Electronic claim files, 835 (electronic remittance advice), batch eligibility and claim status, prior authorization and medical attachments	• **Availity EDI Gateway:** Location for sending and receiving all EDI transactions • To **register** to become an Availity EDI trading partner please visit **Availity.com/provider-portal-registration** • If using third party for your EDI transmissions such as a clearinghouse or billing company, please ensure they have connectivity to the Availity EDI Gateway.

2 PROVIDER PARTICIPATION IN BLUE MEDICARE ADVANTAGE PLANS

2.1 Participation Procedures for Physicians and Physician Group(s)

The Blue Medicare Advantage plans must provide for the participation of individual healthcare professionals through reasonable procedures that include:

a. Written notice of rules of participation
b. Written notice of material changes in participation rules before they become effective
c. Written notice of adverse participation changes, and
d. Process for appealing adverse physician participation decisions

(These requirements also apply to physicians that are part of a subcontracted network.)

Provider agrees that in no event, including but not limited to nonpayment by plan, insolvency of plan or breach of the Agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered individual or persons other than plan acting on their behalf for covered services provided pursuant to the Agreement. This section does not prohibit the collection of supplemental charges or cost shares on plan's behalf made in accordance with the terms of the covered individual's health benefit plan or amounts due for services that have been correctly identified in advance as a noncovered service, subject to medical coverage criteria, with appropriate disclosure to the covered individual of their financial obligation. This advance notice must satisfy the CMS regulations for Medicare Advantage organizations, which currently requires a provider to provide to covered individuals a coverage determination that includes CMS-mandated appeal rights. Both parties agree that failure to follow the CMS regulations will result in a provider's financial liability.

A provider further agrees that for covered individuals who are dual eligible enrollees for Medicare and Medicaid, that a provider will ensure they will not bill the covered individual for cost sharing that is not the covered individual's responsibility and such covered individuals will not be held liable for Medicare Parts A and B cost sharing when the state is liable for the cost sharing. In addition, provider agrees to accept the plan payment as payment in full or by billing the appropriate state source.

CMS has stated that the use of an *Advanced Beneficiary Notice* or a similar document is not sufficient in many instances with Medicare Advantage members. Providers are encouraged to call the toll-free customer service number with any questions around services that may or may not be covered.

Also see Section 2.12 Billing Members and Balance Billing.

2.2 Digital Transactions and Electronic Data Exchange

BMA has developed a Provider Digital Engagement Supplement with the purpose of establishing standards for increasing the use of secure digital provider tools and applications. These tools and applications are accessible to both participating and nonparticipating providers. This supplement is applicable to commercial, Federal Employee Program, Medicaid and Medicare. The products include medical, behavioral health, dental and vision. You can access the digital supplement **here**.

Admission, Discharge and Transfer messaging data
Facilities are asked to provide BMA with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer the message data segments according to the standard HL7 format, or as requested by BMA. On a "near real-time basis" means no later than 24 hours from admission, discharge or transfer for any member.

2.3 Terminating Participation with Blue Medicare Advantage Plans

In the event a provider wishes to terminate his/her participation in either of the Blue Medicare Advantage networks or BMA terminates a provider for reasons other than cause, a mandatory 60-day notification is required for the termination by either party. Please refer to your contract for specific termination requirements.

Any provider requesting termination of his/her participation should send written notification to the BMA Network Management Department in his/her region. Upon receipt of the termination request, BMA will send a written, CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination. MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

2.4 Termination of a Provider Contract with Cause

A Medicare Advantage organization that suspends or terminates an agreement under which the healthcare professional provides service to the Medicare Advantage enrollees must give the affected provider written notice of the following:

- Reason for the action
- Standards and the profiling data used to evaluate the healthcare professional when applicable
- Mix of healthcare professionals the organization needs when applicable
- Affected healthcare professional's right to appeal the action and the process and timing for requesting a hearing.

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional. A Medicare Advantage organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

2.5 Termination of a Provider Contract without Cause

Any provider requesting termination of his/her participation should send a written notification to the BMA Network Management Department in his/her region. Upon receipt of the termination request, BMA will send a written CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination.

2.6 Provider Anti-Discrimination Rules

Plans are prohibited from discriminating with respect to reimbursement, participation or indemnification solely on the basis of a provider's licensure or certification as long as the provider is acting within the scope of such licensure or certification. This prohibition does not preclude any of the following:

- Refusal to grant participation to healthcare professionals in excess of the number necessary to meet the needs of enrollees; a Medicare Advantage (MA) plan may choose to contract with a doctor of medicine that meets the needs of enrollees and does not need to contract with another practitioner who can provide only a discrete subset of physician services.
- Use of different reimbursement amounts for different specialties or within the same specialty

- Implementation of measures designed to maintain quality and control costs consistent with the MA organization's responsibilities.

2.7 Compliance with Medicare Laws, Audits and Record Retention Requirements

Medical records and other health and enrollment information of an enrollee must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular enrollee
- Maintain such records and information in a manner that is accurate and timely
- Identify when and to whom enrollee information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Medicare Advantage member, BMA and providers are obligated to abide by all federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

First tier and downstream providers must agree to comply with Medicare laws, regulations, and CMS instructions (422.504(I)(4)(v)). First tier and downstream providers must also agree to inspections, evaluations and audits by CMS and/or its designees and to cooperate, assist, and provide information as requested **and** must maintain records for a minimum of 10 years.

For the purposes specified in this section, providers must agree to make available its premises, physical facilities and equipment, records relating to the MA Organization's members, including access to provider's computer and electronic system and any additional relevant information that CMS may require.

Providers acknowledge that failure to allow the Department of Health and Human Services, the Comptroller General or their designees the right to timely access as addressed in this section may result in a $15,000 noncompliance penalty.

2.8 Denying claims by excluded and precluded providers

BMA monitors appropriate sanction resource lists to identify providers for whom claims should be denied for its Medicare businesses. For pharmacy providers, the PBM shall be primarily responsible for reviewing the OIG and General Services Administration (GSA) sanction lists in their entirety to ensure no excluded providers are in the pharmacy network. Monthly updates to the sanctions lists are monitored to ensure pharmacies new to the list are not included in the network. For medical providers, BMA Claims monitors the OIG website on a monthly basis to identify sanctioned providers both to prevent payment for medical claims to ineligible providers, and to support correct claim determination complying with Medicare regulations. Further, BMA Provider Data Management monitors the CMS website on a monthly basis to identify precluded providers and prescribers who are prohibited from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries both to prevent payment and to support correct claims determination complying with Medicare regulations.

2.9 Encounter Data

Medicare Advantage Organizations must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner. Facilities and providers who render services to BMA members are required to submit complete claim and encounter data to BMA. In addition, providers have contractually agreed to submit diagnosis code data that is accurate, complete, and truthful (based on their best knowledge, information,

and belief). Data should be submitted through a compliant, electronic 837 submission or on a CMS-1500/UB-04 form, unless other arrangements are approved by BMA. Claim/Encounter submissions should follow industry standards as well as comply with all BMA and CMS requirements.

Electronic 837 industry standards are developed and maintained by the American National Standards Institute and the X12 organization. More information on formatting and compliant submission can be found here: **x12.org/**

Claim and Encounter data submissions are used in a variety of ways, including collecting data related to Healthcare Effectiveness Data and Information Set (HEDIS®) measures and calculating risk adjustment. Risk adjustment was implemented by CMS to pay Medicare Advantage Organizations more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. The Medicare Advantage Organization is required to submit diagnosis information collected from encounter and claim data to CMS for the purposes of risk adjustment.

2.10 Encounter Data for Risk Adjustment Purposes

Risk Adjustment and Data Submission
Risk adjustment is the process used by CMS to adjust the payment made to the Medicare Advantage Organization based on the health status of the Medicare Advantage Organization's Medicare Advantage members. Risk adjustment was implemented to pay Medicare Advantage Plans more accurately for the predicted health cost expenditures of members by adjusting payments based on demographics (age and gender) as well as health status. As an MA organization, diagnosis data collected from encounter and claim data is required to be submitted to CMS for purposes of risk adjustment. Because CMS requires that Medicare Advantage Organizations submit "all ICD-10 codes for each beneficiary", BMA also collects diagnosis data from the members' medical records created and maintained by the provider.

Under the CMS risk adjustment model, the Medicare Advantage Organization is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician encounters only.

CMS Medicare Risk Adjustment Data Validation Audits

As part of the risk adjustment process, CMS performs two different types of validation audits: Contract Level RADV and Part C Improper Payment Measure (IPM) Audits. Both audits are used to validate the MA members' diagnosis data that was previously submitted by Medicare Advantage Organizations. These audits are typically performed once a year. If the Medicare Advantage Organization is selected by CMS to participate in a Contract Level RADV and/or Part C IPM Audit, the Medicare Advantage Organization and the providers that treated the MA members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted and for which Medicare risk adjustment payment was received.
More information related to risk adjustment can be found at **cms.gov**.

Other Risk Adjustment Documentation Reviews and Audits
Providers may be required to submit medical records to BMA for purposes of provider documentation and coding reviews and/or audits. BMA may also engage with providers regarding education and/or remediation to support submission of diagnosis code data that is truthful, accurate, and complete based on best knowledge, information, and belief. Based on the outcome of such documentation and coding reviews and/or audits, providers will be asked and are expected to participate in education and/or remediation.

Medicare Risk Adjustment Provider Education
BMA maintains a library of provider education and training regarding, for example, condition-specific information (e.g., congestive heart failure), Medicare Risk Adjustment (MRA) basics, MRA-related obligations, and medical record documentation and diagnosis coding guidance. Providers are encouraged to explore **provider.bluemedadv.com** and access available trainings. Providers should make their best effort to participate in live (in person or virtual) and/or on-demand training and education opportunities when offered.

ICD-10-CM Codes
CMS requires that providers currently use the ICD-10-CM Codes (ICD-10 Codes) and coding practices for Medicare Advantage business. In all cases, the medical record documentation must support the ICD-10 Codes selected and substantiate that proper coding guidelines were followed by the provider. For example, in accordance with the guidelines, it is important for providers to code all conditions that coexist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the provider code to the highest level of specificity which includes fully documenting the patient's diagnosis.

Medical Record Documentation Requirements (Risk Adjustment)
Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code is assigned;
- They are used to validate diagnosis data that was previously provided to CMS by the Medicare Advantage Organization.

Because of this, the provider plays an extremely important role in ensuring that the best documentation practices are established.
CMS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record.
- Patient's condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT).
- The documentation describing the condition and MEAT must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Provider's signature, credentials and date must appear on record and must be legible.

2.11 Medical Record Review Process
BMA has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. BMA performs medical record reviews to assess network PCPs in relation to current medical record standards. BMA recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires practitioners to comply with the plans' standards for medical record documentation.

Medical record audits/reviews are performed annually on a sample of randomly chosen PCPs contracted for the plans' managed care products for Medicare Advantage networks. For purposes of medical record audits/reviews, a PCP is defined as family medicine, general medicine, internal medicine, pediatrics and

obstetrics/gynecology (when acting as a PCP). A random sampling of these PCPs is identified in the current year and abstracted from the HEDIS® data collection process. See "Medical Record Criteria" listed below.

Medical Record Criteria
The medical record will be evaluated for the following criteria:

1. Every page in the record contains the patient name or ID number.
2. Allergies/NKDA and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
4. A problem list is maintained and updated for significant illnesses and medical conditions.
5. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
6. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
7. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or noncompliance to care plan).
8. Documentation of advance directive/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are MA members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. (We also encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients' files for other, non-MA members.)
9. Continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.
10. Age appropriate routine preventive services/risk screenings are consistently noted, (in other words, childhood immunizations, adult immunizations, mammograms, Pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

Federal regulations require Medicare MCOs and their agents review medical records in an effort to avoid over or under payment and verify medical record documentation support for diagnostic conditions. Additionally, the vice president or local health plan leadership for quality management and the Quality Management Committee conduct medical record audits periodically and use the results in the provider recredentialing process.

BMA may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under 45 CFR § 164.502 (*HIPAA* implementation), providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the *general consent* of the member. A general consent form should be an integral part of your medical record file.

2.12 Federal Funds

BMA has a contract with CMS to perform activities as a Medicare Advantage Organization. In performing its duties as a Medicare Advantage Organization, BMA receives federal payments and, as

such, BMA agrees to comply, and must ensure that all related entities, contractors, and subcontractors paid by BMA to fulfill the BMA obligations under its Medicare Advantage contract with CMS agree to comply, with all federal laws applicable to those entities receiving federal funds. The payments you receive from BMA under this agreement for services rendered to the BMA-covered individuals are, in whole or in part, from federal funds. Thus, you, as a recipient of said federal funds, agree to comply with the following:

- Title VI of the *Civil Rights Act of 1964* as implemented by regulations at 45 CFR part 84
- The *Age Discrimination Act of 1975* as implemented by regulations at 45 CFR part 91
- *The Americans with Disabilities Act*
- *Rehabilitation Act of 1973*
- Other laws applicable to recipients to federal funds, and
- All other applicable laws and rules.

2.13 Prompt Payment by Medicare Advantage (MA) Organization

Receipt of claims by noncontracted providers will be considered a "clean claim" if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare. The MA organization is bound to adhere to the following prompt payment provisions for noncontracted providers:

- Pay 95% of clean claims within 30 days of receipt
- Pay interest on clean claims not paid within 30 days
- All other claims must be approved or denied with 60 calendar days from date of receipt

All contracted providers must include a prompt payment provision in their contract, the terms of which are developed and agreed to by the MA organization and the provider. Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified time frame, the claim will be closed and the provider will be notified.

The MA organization may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a physician or other practitioner who has opted out of the Medicare program by filing with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at **cms.gov**. You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

If you are a contracting provider, please refer to you contract for the prompt payment terms applicable to you.

2.14 Billing Members and Balance Billing

Cost-Sharing

An important protection for beneficiaries when they obtain plan-covered services in a PPO is that they do not pay more than plan-allowed cost sharing. Providers who are permitted to balance bill must obtain this balance billing from the Medicare Advantage Organization (MAO). Providers may **not** collect any additional payment for cost-sharing obligations from Medicare members other than those specified in a member's plan *Summary of Benefits*.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS-5010* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of MA plan, noncontracting and Original Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider
There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare)-participating provider
The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the members' cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.
- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan allowed cost-sharing, which equals:
  - The copay amount, if the MAO uses a copay for its cost-sharing; or
  - The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in the "*MA Payment Guide for Out of Network Payments*," at **cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.**

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefi*ts (SOB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting, nonparticipating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Recovery Look-Back Period
To align with CMS guidelines, 42 CFR § 405.980, 405.986, BMA recovers Medicare Advantage claim overpayments within four years of the claim payment date. In addition, CMS' Medicare Integrity Program employs Recovery Audit Contractors to identify and correct improper Medicare payments. The RAC program allows for a look-back period of up to five years.

2.15 Recoupment/Offset/Adjustment for Overpayments of Contracting Providers

BMA shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by BMA to a provider against any payments due and payable by BMA to a provider under the *Participating Provider Agreement*. The provider shall voluntarily refund all duplicate or erroneous claim payments regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, noncompliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by BMA that any recoupment, improper payment, or overpayment is due from a provider, provider must refund the amount to BMA within 60 days of when BMA notifies a provider. If such reimbursement is not received by BMA within the 60 days following the date of such notice, BMA shall be entitled to offset such overpayment against other amounts due and payable by BMA to a provider in accordance with regulatory requirements. BMA reserves the right to employ a third-party collection agency in the event of nonpayment.

2.16 Use of BMA trademark within communications

BMA welcomes you to use our name and logo along with other information, such as how a person may contact us, when you send out communications to your patients. In order to use the BMA name or logo within a communication, a provider must first obtain permission from BMA as noted within your provider contract. Our provider contracts stipulate that any printed materials, including but not limited to letters to plan-covered persons, brochures, advertisements, telemarketing scripts, packaging prepared or produced by a provider or any of his/her/its subcontractors pursuant to this *Participating Provider Agreement* must be submitted to the plan to assure compliance with federal, state, and Blue Cross/Blue Shield Association guidelines. BMA agrees its approval will not be unreasonably withheld or delayed. In order to make this easier on you the provider, we have simplified the submission of the document(s) to BMA for review.

To submit a document for review, please send the copy to your local Provider Relations Consultant. Once the copy is submitted it will be the responsibility of your local Provider Relations Consultant to insure that the internal BMA legal review is completed in a timely manner. Although the BMA legal team will be reviewing the copy, it is your responsibility to comply, and to require any of your subcontractors to comply, with all applicable federal and state laws, regulations, CMS instructions, and marketing activities under this *Participating Provider Agreement,* including but not limited to, the *National Marketing Guide* for Medicare Managed Care Plans, and any requirements for CMS prior approval of materials. We again welcome you to use our name and logo when you send out communications to you patients in an effort to provide information to your patients.

2.17 PPO Provider Network Sharing

Network sharing allows MA PPO members from MA PPO Blue Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a provider contracted with a Blue Medicare Advantage PPO plan in one of the areas listed below. Medicare Advantage PPO shared networks are available in 32 states and one territory:

Alabama	Arkansas	California	Colorado	Connecticut	Florida
Georgia	Hawaii	Idaho	Indiana	Kentucky	Maine
Massachusetts	Michigan	Missouri	N. Carolina	Nevada	New Hampshire
New York	Ohio	Oregon	Pennsylvania	Puerto Rico	S. Carolina
Tennessee	Utah	Virginia	Washington	Wisconsin	West Virginia
Montana	New Mexico	Oklahoma			

If you are a contracted MA PPO provider with BMA and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your BMA contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with BMA and you provide services for any Blue Medicare Advantage members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

You can recognize a MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo.

The *"*MA*"* in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

If you are a contracted Medicare Advantage PPO provider with BMA, you must provide the same access to care as you do for the BMA Blue MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

If your practice is closed to new local Blue MA PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

To verify a member's eligibility, call the BlueCard Eligibility Line at **800-676-BLUE** (**800-676-2583**) and provide the member's three-digit alpha prefix located on the ID card.

You should submit claims to BMA under your current billing practices. If you are a MA PPO contracted provider with BMA, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, BMA will work with the other plan to determine benefits and send you the payment. When you provide covered services to other Blue Medicare Advantage out-of-area members, benefits will be based on the Medicare allowed amount. Once you submit the MA claim, BMA will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

A MA PPO member cost sharing level and copay is based on the member's health plan. You may collect the copay amounts from the member at the time of service. To determine the cost sharing and/or copay amounts, you should call the BlueCard Eligibility Line at **800-676-BLUE** (**800-676-2583**). You may not

balance bill the member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or copays. If there is a question concerning the reimbursement amount or questions regarding any part of the MA PPO network sharing, contact BMA at the number on the back of the member's ID card.

2.18 Contracted Provider Assistance with Medicare Advantage Material

As part of the BMA goal to improve the health of the senior community, we are committed to providing them with the facts about our Medicare Advantage healthcare plans that help seniors make more informed decisions about their healthcare and coverage needs. To assist with meeting the goal to keep Medicare beneficiaries more informed, we need your help. BMA would like to make Medicare Advantage materials available to beneficiaries through our contracted providers. We are asking your permission to display Medicare Advantage materials in your offices. Our sales representatives will be contacting you and other contracted providers to work with BMA to provide this information to beneficiaries.

Your participation with this request is strictly voluntary; however, as with all provider-based activities, CMS has certain requirements for both the Medicare Advantage sponsor of these materials and the contracted providers (and any subcontractors, including providers or agents) who display the materials in their offices.

CMS Guidelines

Providers contracted with Medicare Advantage (and their contractors) are permitted to:

- Provide the names of Medicare Advantage sponsors with which they contract and/or participate to beneficiaries.
- Provide information and assistance in applying for the Low Income Subsidy (LIS).
- Make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all plans with which they participate. CMS does not expect providers to proactively contact all participating plans to solicit the distribution of their marketing materials: rather, if providers agree to make available and/or distribute plan marketing materials for some of their contracted plans, providers should do so knowing they must accept future requests from other plans with which they participate.

To that end, providers are permitted to:

Provide objective information on Medicare Advantage sponsors' specific plan formularies, based on a particular patient's medications and healthcare needs.

- Provide objective information regarding Medicare Advantage sponsors', including information such as covered benefits, cost sharing and utilization management tools.
- Make available and/or distribute plan marketing materials including Prescription drug plan (PDP) enrollment applications, but not Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD enrollment applications for all plans with which the provider participates.
- To avoid an impression of steering, providers should not deliver materials/applications within an exam room setting.
- Refer their patients to other sources of information, such as State Health Insurance Plan SHIPs, plan marketing representatives, their state Medicaid Office, local Social Security Office, CMS' website at **medicare.gov** or **800-MEDICARE (800-633-4277**).
- Print out and share information with patients from CMS' website.
- **Providers are permitted to make available and/or distribute plan marketing materials for a subset of contracted plans only as long as providers offer the option of making available and/or distributing marketing materials to all.**

The *Medicare & You Handbook* or Medicare Options Compare (from **medicare.gov**), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by Medicare Advantage sponsors and providers without further CMS approval. This includes CMS Medicare Prescription Drug Plan Finder information via a computer terminal for access by beneficiaries. Medicare Advantage sponsors should advise contracted providers of the provision, based on a particular patient's medications and healthcare needs.

2.19 Delegation

Delegated Activities

If BMA has delegated activities to the provider, then BMA will provide the following information to the provider and the provider shall provide such information to any of its subcontracted entities:

- A list of delegated activities and reporting responsibilities;
- Arrangements for the revocation of delegated activities;
- Notification that the performance of the contracted and subcontracted entities will be monitored by the plan
- Notification that the credentialing process must be approved and monitored by the plan; and
- Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

Delegation of Provider Selection

In addition to the responsibilities as set forth above, to the extent that the plan has delegated selection of the providers, contractors, or subcontractor to the provider, the plan retains the right to approve, suspend, or terminate any such arrangement.

2.20 Misrouted Protected Health Information (PHI)

Providers and facilities are required to review all member information received from BMA to ensure no misrouted PHI is included. Misrouted PHI includes information about members that a provider or facility is not currently treating. PHI can be misrouted to providers and facilities by mail, fax, or email. Providers and facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are providers or facilities permitted to misuse or redisclose misrouted PHI. If providers or facilities cannot destroy or safeguard misrouted PHI, providers and facilities must contact Provider Services to report receipt of misrouted PHI.

3 UTILIZATION MANAGEMENT MEDICARE ADVANTAGE PLANS

Components of utilization management for Blue Medicare Advantage plans:

- Application of Clinical Criteria Guidelines
- Referral management
- Referring out-of-network
- Prior Authorization
- Concurrent review
- Denials
- Emergency care/urgent care
- Case management
- Under and over utilization

Application of Clinical Criteria Guidelines
BMA uses Medicare coverage guidelines, nationally recognized clinical guidelines, and internally developed guidelines for medical appropriateness review. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the criteria. Medical necessity decision making includes assessing the needs of the individual patient and characteristics of the local delivery system.

BMA uses the following utilization management criteria for their MA plans:

- **Medicare Coverage Directives** are the primary criteria used in making decisions regarding coverage for the Blue Medicare Advantage plans. Medicare Advantage plans are required to provide their Medicare enrollees those services that are covered under Medicare and available to other

fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that coverage determinations for our members must be in accordance with CMS national coverage decisions, as well as local coverage determinations by Medicare intermediaries and carriers. Medicare Coverage Directives includes CMS National and Local Coverage Determinations or other Medicare guidance including Medicare Policy Benefit Manuals, Medicare Managed Care Manuals, Medicare Claims Processing Manuals, and Medicare Learning Network, etc.

- **BMA Medical Policy** is developed to assist in interpreting contract benefits. Medical policy includes technology assessment and medical requirements for coverage of selected technologies and services. These guidelines are available upon request.
- **Medically Necessary (or Medical Necessity)** means services, treatments, diagnostic procedures, or supplies provided to members that are medically required and appropriate to diagnose and/or treat a member's physical or mental condition. Also, such services, treatments, diagnostic procedures, or supplies must: 1) meet widely accepted evidence-based criteria and professionally recognized standards of healthcare; 2) not be used primarily for the comfort or convenience of the member, the member's family or caregiver, or the member's treating physician; 3) not be excessive in cost as compared to alternative services or supplies effective for the diagnosis and/or treatment of the member's physical or mental condition; and 4) not be provided to the member as an inpatient when the services or supplies could be safely and appropriately provided to the member in an outpatient setting.

Guidelines are also developed for disease management and preventive services. These guidelines are available upon request or at **BMA.com/medicareprovider** within the MA Product pages under *Additional Information.*

3.1 Use of Clinical Guidelines

Application of criteria must be reviewed in the context of the individual member and consider age, co-morbidities, extenuating circumstances and/or complications, response to treatment, psychosocial issues, support network, and home environment. In the application of decision criteria for specific consumers, relevant characteristics of the local delivery system are considered, including, but not limited to, the availability of certain types of facilities or services within the service area and the capability of facilities or other providers to offer needed services.

The hierarchy for UM criteria application will be applied to all medical necessity determinations for coverage for services provided to members eligible for benefits under Medicare Advantage products. CMS national and local coverage guidelines are referenced first for all medical necessity reviews.

If there is no guidance or criteria available in CMS, the BMA Corporate Medical Policies followed by evidence-based guidelines, such as MCG Guidelines criteria, Compendia, NCCN (*National Comprehensive Cancer Network Clinical Practice Guidelines*) may be used.

BMA Corporate Medical Policy

BMA decision criteria incorporate nationally recognized standards of care and practice, current professional literature, and cumulative professional expertise and experience. The decision criteria used by senior business clinical reviewers are evidence based and consensus-driven. Criteria are updated as standards of practice or technology change. Actively practicing physicians and other relevant practitioners are involved in the development and adoption of the review criteria. An annual review and approval is performed by the Medical Policy and Technology Assessment Committee (MPTAC) or when applicable for certain specialty areas, another national clinical committee that utilizes comparable procedures for development of decision criteria. The criteria are reviewed annually for approval and adoption by the BMA-affiliated companies.

3.2 Referral Management

PPO members are encouraged to select a PCP who serves as the coordinator of care to ensure access to appropriate medically necessary specialty care. When referring a member to a specialist, selecting a participating provider within our Medicare network will maximize the members benefit and minimize their out-of-pocket expenses. If you need help finding a participating provider, please call Provider Services or if you believe you must refer to a provider outside of our network, you must contact BMA in advance of that request in order for an organization determination to be made. Failure to initiate this request may result in claims denials and member liability. This includes such services as laboratories; however, it does not include urgent, emergent or out-of-area renal dialysis services.

3.3 Self-Referral Guidelines

Medicare members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- All preventive services (for example, routine physical examinations, prostate screening and preventive women's health services, such as Pap tests)
- Case Management

Blue Medicare Advantage PPO members can utilize providers both in and out of the network.

- Out-of-network referrals do not require plan notification or authorization however can be requested and is encouraged for some services to ensure there is no delay in claims processing as out-of-network services are subject to a medical necessity review upon claims submission, if not

precertified. Services deemed to be noncovered will result in the claim denying with member liability unless urgent, emergent, out-of-area renal dialysis or when prior approval has been provided by the plan.

- Out-of-network services are subject to the member's out-of-network cost share. Blue Medicare Advantage PPO members also will have less out-of-pocket expense if they select a provider in the network.

3.4 Referral Guidelines

Although not required, prior authorization is encouraged for PPO members who want to receive notification of advanced coverage when utilizing an out-of-network provider for services generally precertified.

3.5 Providing Noncovered Services Advanced Notification

For services that require prior authorization or are noncovered by the plan (in other words statutory exclusion), it becomes extremely important that BMA authorization procedures are followed. If a member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow BMA authorization protocols, Blue Medicare Advantage will decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS issued guidance concerning the Advanced Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-for-Service document and cannot be used for Medicare Advantage denials or notifications. Per the ***CMS Medicare Claims Processing Manual*** (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If you have any doubt about whether a service is not covered, please seek a coverage determination from the plan.

3.6 Access to Care and Services

Blue Medicare Advantage will not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in a Medicare Advantage (MA) plan offered by an organization on the basis of any factor that is related to health status. This includes but is not limited to the following: medical condition, claims experience, receipt of healthcare, medical history, genetic information, evidence of insurability and disability, except as it relates to end-stage renal disease. The Blue Medicare Advantage Plans must meet the requirement to provide coverage and payment for all services that are covered under Part A and Part B of Medicare. The Medicare Advantage Organization must ensure that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under the plan. Medically necessary services must be available 24/7.

There are also instances where an in-network provider is not available for members in our PPO's. In those instances, the in-network provider should collaborate with our utilization management area to obtain authorization for out of network services. In certain circumstances, the member may only be responsible for the in-network cost sharing.

Providers and suppliers must be located throughout the service area. Services are generally considered accessible if they reflect usual practice and travel patterns in the local area. Generally, hospital and PCP services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care services exceed 30 minutes as in some rural areas.

Appointment access standards for primary care services are:

Service	Access Requirement
Emergency	Immediate 24 hours a day/seven days a week access available — for emergent diagnoses. Behavioral health providers must be available to assess a patient experiencing an emergent situation within 6 hours.
Urgent	Within 48 hours — including behavioral health urgent services.
Routine	Within 10 business days — including behavioral health routine services.
EDI Rejected Claim(s)	Contact Availity Client Services at **800-Availity** (**800-282-4548**). Availity Client Services is available Monday through Friday, 8 a.m. to 8 p.m. ET. Web: **Availity.com**

Organizations and providers who contract with the Blue Medicare Advantage network are required to establish and implement appropriate treatment plans for a member with complex and serious medical conditions. Accordingly, an established treatment plan must include an adequate number of direct access visits to relevant specialty providers. Treatment plans must be time-specific and updated by the PCP.

The BMA medical management department will coordinate authorizations for members affected by a provider termination when they are undergoing treatment for specific conditions. Members not undergoing treatment at the time of a provider termination will be referred to their PCP for a referral to another participating provider of that like specialty.
Plans may select the providers through whom services are provided as long as:

- The plan makes services available and accessible within the service area with reasonable promptness and in a manner, which assures continuity.
- The plan provides access to appropriate providers, including credentialed specialists, for medically necessary care; and if a network provider is unavailable or inaccessible then the MA organization must arrange for services outside of the network.
- Coverage is provided for emergency services without regard to prior authorization or whether the provider was a participating provider.
- The plan maintains and monitors a network of appropriate providers.
- The plan gives women enrollees direct access to women's health specialists within the network for women's routine and preventive healthcare services.
- The plan establishes written standards for timeliness of access to care and customer service that meet or exceed standards established by CMS and continuously monitors to assure continuous compliance with standards.
- The plan ensures services are provided in a culturally competent manner.
- The plan ensures services are available 24/7 when medically necessary.

- The MA organization ensures continuity of care and integration of services and makes a "best effort" attempt to conduct an initial assessment of an enrollee's healthcare needs within 90 days of enrollment.

** Not all contracting providers have to be located within the service area, but CMS must determine that all services covered under the plan are accessible from the service area.*

3.7 Direct Access to Preventive/Routine Gynecological and Mammography Services

Members in the Medicare Advantage PPO may choose either a network or a non-network provider. Please refer to the most recent Medicare Advantage provider directory for the Mammography Center and OB/GYN specialty provider listings. Our provider directories are also available online at **BMA.com/medicareprovider**.

3.8 Direct Access to Influenza and Pneumococcal Immunizations with no Cost Sharing

BMA strongly encourages all members to receive influenza and pneumococcal immunizations. No referral or copay for the immunization is required.

3.9 Prior Authorization

BMA must be notified of as early as possible before all planned inpatient admissions and no later than one business day after an unplanned inpatient admission. For services including but not limited to: selected diagnostic, outpatient and inpatient procedures, prior authorization must be requested at a minimum of 72 hours in advance. UM associates will be requesting relevant clinical information, including signs, symptoms, treatment plans, diagnostic test results, medical records and attempts at conservative treatment (when appropriate) in order to complete the prior authorization process.

Providers are required to provide notification in advance of services to allow BMA to meet CMS processing timeframes:
Medical:

- Standard — 14 calendar days
- Expedited — 72 hours

Pharmacy (Including Part B Medical injectables)

- Standard — 72 hours
- Expedited — 24 hours

Note: BMA requires notification within one business day for all ER admissions.

CMS defines an expedited/urgent request as a request in which waiting for a decision under the standard time frame could place the member's life, health or ability to regain maximum function in seriously jeopardy. Contracted providers should submit requests in accordance with CMS guidelines to allow for organization determinations within the standard turnaround time, unless the member urgently needs care based on the CMS definition of an expedited/urgent request.

3.10 Interactive Care Reviewer (ICR)

The BMA ICR is the preferred method for the submission of preauthorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical services.

Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent.

- Initiate preauthorization requests online, eliminating the need to call or fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests using digital tools.
- Instant accessibility from almost anywhere including after business hours.
- Use the dashboard to provide a complete view of all UM requests with real-time status updates including email notifications if requested using a valid email address.
- Real-time results for some common procedures with immediate decisions.
- Access ICR under *Authorizations and Referrals* via Availity Essentials (**Availity.com**).

For an optimal experience with the BMA ICR, use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari. The BMA ICR is not currently available for the following:

- Transplant services.
- Services administered by vendors such as Carelon Medical Benefits Management, Inc. (For these requests, follow the same prior authorization process you use today.)

Our website will be updated as additional functionality and lines of business are added throughout the year.

A BMA Medical Management Clinician will review each request for admission, procedures or services. If evidence-based criteria are met, the review clinician will document clinical data and authorize the requested service. Approval letters are mailed to the member, the PCP, the hospital and the attending physician within one business day of the decision. If the review nurse determines that the criteria are not met, or there is insufficient information to complete a review, the request for service is referred to a medical director for review. Only physicians, or other appropriate healthcare professionals, as defined by CMS, are able to render medical necessity denials. If a denial decision is indicated, the notification includes information regarding the appeal process, availability of a physician to discuss the case, and the reason for the denial including the specific clinical criteria or benefits provision.

Appropriately licensed and trained professionals make UM decisions according to established criteria. Nonclinical associates, under the supervision of a licensed professional, may collect nonclinical data and may approve cases that do not require clinical review. Board-certified practitioners are utilized in making decisions of medical necessity. Again, only physicians, or other appropriate healthcare professionals, as defined by CMS, are able to render denials. Practitioners from appropriate specialty areas are used as needed for medical necessity reviews and appeals.

Please contact your local provider relations department to obtain the most current copy of the MA prior authorization list.

3.11 How to request a Prior Authorization

Failure to request a prior authorization for an admission or provide notice of emergent inpatient admission will result in an administrative denial. Notify BMA as early as possible before a planned admission and no later than one business day after an unplanned inpatient admission.

If the required prior authorization is not obtained within the specified time frame, the claim will be administratively denied due to failure to notify BMA of the admission. The provider will not receive payment for the service. Providers cannot bill the member for these denied services.

If you do not notify us within the required time frame, you may file a plea indicating the reason for the failure to provide timely notification as per above. **Appeals for failure to provide timely notification will not be reviewed clinically until the late notification denial is resolved.** When submitting a response to a denial for failure to notify, the reason for the failure to provide proper notification should be presented. If your justification is accepted, the case will be sent for initial review and any adverse determination for medical necessity will be provided with subsequent appeal rights. Note, BMA will not request information to justify the reason for late or no notification, nor if the notification requirement is waived will BMA request medical records for any subsequent review.

To obtain authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Prior Authorizations, Observation and Timely Notification Reminders for Medicare Advantage Members

Getting the best care in the most appropriate setting is key to achieving the best outcomes for our Medicare Advantage members. These members rely on their healthcare professionals and their health plan to help coordinate this important aspect of their care. To do this, timely requests for service and communication is essential.

Please be aware of the following considerations and requirements to help ensure effective coordination of care for Medicare Advantage members and assure consistent application of the Centers for Medicare and Medicaid Services guidelines and /or nationally recognized evidence based medical necessity guidelines) for pre- and post-service medical necessity and site of service reviews.

Emergent Inpatient Acute Medical Admissions

Hospitals are required to notify and/or obtain an authorization as early as possible, but no later than within one business day of admission. The process for decision making is fastest when all supporting clinical information is submitted and includes test results (as applicable) and member's response to emergency treatment.

Planned Inpatient Admissions

Prior authorization is required for **all** planned inpatient admissions. The request for prior authorization for a planned inpatient stay should occur as soon as the provider determines the need for the inpatient admission. Providers should submit prior authorization requests in advance of the inpatient admission to allow for CMS processing timeframes. CMS standard processing timeframe is 14 calendar days, expedited processing timeframe is 72 hours. Services may not be reimbursable if the prior authorization is not obtained.

Hospital observation, in-patient admission and timely notification

Please notify us as soon as possible following admission but no later than within one business day of admission.

If we don't receive notification of admission, a retrospective review for medical necessity and site of service per the above hierarchy of review, will be conducted when the claim is submitted.

3.12 Inpatient Acute Concurrent Review

BMA performs concurrent review for Medicare Advantage members at contracted in-area hospitals. The review's purpose is to continuously improve medical care by:

- Determining the need for continued stay
- Initiating discharge planning and case management.

3.13 Skilled Nursing Facility

Prior Authorization for admission to skilled nursing facilities

According to CMS guidelines, patients should be admitted to a skilled nursing facility when "… as a practical matter, considering economy and efficiency, the daily skilled services can be provided only on an inpatient basis in a SNF.*

Skilled nursing, acute rehabilitation and long-term care facilities are required to obtain prior authorization for Medicare Advantage members before that member can be admitted. For the member to receive maximum benefits, the health plan must authorize or precertify the admission. To assure payment according to contract, before a Medicare Advantage member is transferred to the receiving facility, the facility must notify the plan and receive prior authorization for that transfer.

Please note:

- Prior Authorization includes a review of both the service and the setting.
- Please present the request for admission to a skilled nursing facility, acute rehabilitation facility, and/or long-term acute care facility prior to admission.
- Please provide all supporting documentation with the request for prior authorization at the time of the request for admission.
- If the required prior authorization is not obtained prior to the service, the claim may be administratively denied for all days accrued prior to receiving an approval for admission, in accordance with your provider contract.
- To obtain prior authorization or to verify member eligibility, benefits and account information, please call the telephone number listed on the back of the member's identification card.

Please refer to your provider agreement, this provider manual, and the Medicare Advantage *Prior Authorization Guidelines* found at the Medical Policy, UM Guidelines and Prior Authorization Requirements link on the BMA provider home page at **BMA.com/medicareprovider** for further information on prior authorization and prior authorization requirements.

Please share this information with clinical staff and others involved with facility authorization and admissions.

We look forward to working with you and your colleagues to ensure our members are discharged at the right time clinically, to the right place and achieve the best clinical outcome.

BMA will coordinate skilled nursing facility (SNF) benefits for our Medicare Advantage members. Inpatient SNF coverage is limited to 100 days each benefit period based on medical necessity. Blue Medicare Advantage plans waive the Original Medicare requirement for the three-day inpatient hospital stay for skilled coverage. Thus, the physician may directly admit a member into a SNF from various sites, including the office, home or from an observation stay.

Care in a SNF is covered if **all** of the following three factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, in other words, services that must be performed by or under the supervision of professional or technical personnel.
- The patient requires these skilled services on a daily basis.
- The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered. If a stay in a SNF is not covered, Medicare Part B services

may still be obtained and members will be assessed the applicable copays. A benefit period is used to determine coverage under the Blue Medicare Advantage plans in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the member has been out of the hospital or SNF for 60 consecutive days.

* *Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance (Rev. 155, 04-20-12)*

Inpatient stays solely to provide custodial care are not covered under Blue Medicare Advantage plans. Custodial care is defined as care furnished for the purpose of meeting non-medically necessary personal needs that could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Blue Medicare Advantage plans or Original Medicare does not cover custodial care unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

The obligation on the provider to follow coverage limits for Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a provider furnishes Original Medicare, SNF and inpatient hospital services to enrollees of Medicare Advantage Organizations. This obligation applies to all SNFs and applies to both teaching and nonteaching hospitals. This obligation can be implemented by providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with condition code, 04). It is also the provider's obligation to keep an audit trail on these claims.

3.14 Home Health Services

For a member to qualify for home health benefits, the member must be confined to the home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service. Under the Blue Medicare Advantage plans, the member does not have to be bedridden to be considered confined to home. The condition of the member should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require considerable and taxing effort. If the member leaves the home, the member is still considered homebound if the absences from the home are infrequent, for periods of relatively short duration or to receive medical treatment. Home care includes the following services:

- Part-time or intermittent skilled nursing and home health aide services
- Physical, occupational, and speech therapy
- Medical social services
- Medical supplies
- DME
- Portable X-rays and EKGs
- Laboratory tests

3.15 Denials

Pre-Service Denials and Lack of Information

Lack of information denials may not be issued to Blue Medicare Advantage (MA) members. CMS does not recognize denials due to a lack of information. Therefore, when there is not enough information to certify or deny a requested service requiring utilization management review, further attempts must be made to collect the missing information. If sufficient information is not received, the pre-service request will be referred to the medical director or physician consultant for medical necessity determination.

Denials for emergent inpatient admissions, discontinuation of coverage

Based on the application of our clinical criteria guidelines, if the admission or continued inpatient stay does not meet medical necessity criteria, it is referred to the medical director or physician consultant for medical necessity determination. Physician review decisions are made within one working day. Plan providers are also entitled to a physician-to-physician review.

Hospital discharge appeal notices/important message from Medicare
Hospitals must notify Medicare Beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirement for providing the Important Message from Medicare (IM), including the time frames for delivery. For a copy of the notice and additional information regarding this requirement, go to ***CMS Beneficiary Notices Initiative (BNI)*** at **cms.gov/Medicare/Medicare-General-Information/BNI/index?redirect=/BNI/12_HospitalDischargeAppealNotices.asp**.

Notice of Medicare Noncoverage Requirements
CMS requires 100% compliance of providers to deliver a *Notice of Medicare Non-Coverage* (*NOMNC*) to every Medicare beneficiary at least two days prior to the end of their skilled nursing facility, home health, or comprehensive outpatient rehabilitation facility (CORF) care.

BMA has established policies and procedures that require skilled nursing facilities, home health agencies, and CORFs to comply with the CMS mandatory requirement for all Medicare beneficiaries enrolled in Medicare Advantage Plans to receive a valid *Notice of Medicare Non-Coverage* (*NOMNC*), in a timely manner at the termination of care by a skilled nursing facility (SNF), home health agency, or CORF to allow the member the opportunity to appeal to the Quality Improvement Organization (QIO), in the event they disagree with the termination of services. For a copy of the notice and additional information regarding this requirement, go to ***CMS Beneficiary Notices Initiative (BNI)*** located at **cms.gov/Medicare/Medicare-General-Information/BNI/index?redirect=/BNI/12_HospitalDischargeAppealNotices.asp**.

BMA responsibility and liability for SNF termination of services
When Blue Medicare Advantage makes a decision to terminate coverage of a member's services in a SNF, a valid *NOMNC* is sent to the SNF for the member to receive the *NOMNC* at least two calendar days in advance of the services ending, even if the member agrees with services ending, in compliance with CMS regulation.

BMA is extending the notice period up to 8 p.m. (in the time zone the facility is located), with the next two calendar days following the date of the denial notice to be considered the required two-day notice.

Below is an outline of determining the last approved day after the decision has been rendered to end services:

If denial notice (*NOMNC*) issued with confirmation of verbal notification and appeal information provided to the member, on the below day and time in the time zone the facility is located	Then last approved day (LAD) will be on	Members' discharge will occur or member financial responsibility will begin on
Monday (12 a.m. to 8 p.m.)	Wednesday	Thursday
Tuesday (12 a.m.to 8 p.m.)	Thursday	Friday
Wednesday (12 a.m. to 8 p.m.)	Friday	Saturday
Thursday (12 a.m. to 8 p.m.)	Saturday	Sunday
Friday (12 a.m. to 8 p.m.)	Sunday	Monday
Saturday (12 a.m. to 8 p.m.)	Monday	Tuesday

If denial notice (*NOMNC*) issued with confirmation of verbal notification and appeal information provided to the member, on the below day and time in the time zone the facility is located	Then last approved day (LAD) will be on	Members' discharge will occur or member financial responsibility will begin on
Sunday (12 a.m.to 8 p.m.)	Tuesday	Wednesday

The BMA verbal notification to the member and/or verbal or fax receipt confirmation of the delivery of the *NOMNC* submitted prior to 8:01 p.m. (in the time zone the facility is located), will be considered a valid delivery date/time to the facility.

BMA Contracted SNF Provider Responsibility and Liability
The SNF providers are responsible for delivering the *NOMNC* on behalf of BMA, to the member or representative **and** for obtaining signature(s) the same day received by BMA, but no later than two days before the member's covered services end. In the event the SNF is not able to deliver the *NOMNC* and obtain signature(s) the same day BMA issues the *NOMNC*, the SNF provider is responsible for reissuing a *NOMNC* with the appropriate LAD to allow the member at least two calendar days in advance of the services ending.

In the event the member is in need of an authorized representative to acknowledge/sign the *NOMNC*, and the SNF is unable to deliver it to the authorized representative the same day BMA issues it, the SNF should telephone the representative the same day the *NOMNC* is issued, to advise him/her when the beneficiary's services are no longer covered. The date of the conversation is the date of the receipt of the notice. The NOMNC must be annotated to note the name of the staff person initiating the contact, the name of the member representative contacted by telephone, the date and time of the telephone contact, and the telephone number called. The annotated *NOMNC* must be mailed on the same day. The SNF must retain a copy of the annotated NOMNC in the member's medical records.

The SNF provider is also responsible to issue a *NOMNC* (created by the SNF provider) for members who services are expected to be fewer than two days duration or when a guaranteed discharge date is in place.

Liability will remain with the SNF in the event the acknowledgement of receipt and delivery of the *NOMNC* to the member or member's representative is not completed within the same day received. The authorization through the last approved day (LAD) will remain the same for the facility. The member may receive a new *NOMNC* with a new LAD to extend the covered services, with no liability to the member or BMA, in order to allow the member adequate days/time to appeal to the QIO, should the member disagree with the termination of services.

Blue Medicare Advantage Member Responsibility and Liability
The member or representative is responsible for acknowledging receipt of the *NOMNC* by signing the document. The member or representative is also responsible for contacting the QIO (no later than noon of the first day after receiving the *NOMNC*), if he or she wishes to appeal the termination and obtain an expedited review. The member may also make an expedited pre-service appeal request to the BMA Medicare Complaints, Appeals and Grievances Department should they miss their time frame for appealing to the QIO and are still in the facility.

Liability for the member will begin the day following the last approved day as specified on the *NOMNC*, should the member choose not to appeal the termination of services.

Note: QIOs must be available to receive a member's appeal request 24 hours a day, seven days a week.

Refer to the Provider and Member liability section of the provider contract with BMA for further details.

3.16 Preservice denials

When a contracted provider is denied a pre-service request for a member, federal regulations require the Medicare Advantage Organization to issue written notice of the denial (a *Notice of Denial of Medical Coverage* (*NDMC*) also known as the Integrated Denial Notice (IDN)) informing the member of his/her appeal rights. Therefore, a physician or practitioner is required as a matter of routine to notify members about their right to receive such information. The notice to the member must provide, in addition to information about the right to receive detailed information, all information necessary to allow the member to contact the health plan.

3.17 Special Rules for Emergency and Urgently Needed Services, Post-Stabilization Care, and Ambulance Services

The Blue Medicare Advantage plan is financially responsible for emergency services provided by contracted and noncontracted providers where services are immediately required because of an emergency medical condition. The plan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

A Medicare Advantage Organization is required to cover emergency services for its MA members regardless of whether the services were preauthorized or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Urgently needed services are not emergency services as defined above, but are covered services which are medically necessary and immediately required as a result of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain the services through the organization. For example, urgently needed services are covered when:

- An enrollee is temporarily absent from the MA plan's service area.
- When the enrollee is in the service area and there are extraordinary circumstances that cause the provider network to be temporarily unavailable or inaccessible.

Post-stabilization care is defined as covered services pertaining to an emergency medical condition provided after the member is stabilized. It is to be determined by the attending physician and under specific circumstances includes care to improve or resolve the enrollee's condition. The treating physician is responsible for determining when the member is considered stabilized for transfer or discharge. For the purposes of this requirement, post-stabilization care and maintenance care are used synonymously. The plan's financial responsibility for post-stabilization care services includes:

- Any service administered, even though not preapproved by the plan or its representative, during the one-hour period following the request to the MA organization for preapproval of further post-stabilization care.

- Services administered to maintain, improve, or resolve the enrollee's stabilized condition if the MA organization does not respond to the request for preapproval within one hour.
- The MA organization's representative and the treating physician cannot reach an agreement concerning care decisions and a plan physician is not available for consultation.

The plan's financial responsibility for post-stabilization care ends when:

1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
- A plan physician assumes care through transfer.
- The MA organization's representative and the treating physician reach an agreement on the member's care.
- The member is discharged.

3.18 Case Management

Case management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' healthcare benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes. The program utilizes proprietary predictive models to identify members with a variety of conditions who may potentially benefit from case management. Members who might benefit from case management are identified through a referral process. Case management referrals will be accepted from both internal and external sources.

- Internal sources include, but are not limited to, utilization management associates, customer service associates, account managers, appeals/grievance associates, and sales staff.
- External sources include, but are not limited to, hospital staff, discharge planners, social services, physicians and other healthcare providers, members or their families.
- BMA discharge planners collaborate with all pertinent parties in the development of the discharge plan (in other words, PCP, specialist, Medical Director) to ensure the members needs are met before the member leaves the hospital setting. BMA has designed a platform that provides a single point of contact to providers and facilities to ensure effective and collaborative discharge planning – of which streamlines the process for our providers while providing a more proactive, informative, and comprehensive transition for the member and their care partner to fully understand the care plan in other words, ensuring ancillary needs are met (DME received before member returns home, home infusion training is required, etc.). Additional intensified discharge planning efforts also include:
    - Performing medication reconciliation
    - Refer members to high-risk condition management programs, where applicable
    - Manage palliative care needs and refer to hospice when appropriate
    - Integrate psych and social workers where necessary

In addition, case referrals can be generated prospectively from the UM system during the prior authorization process and retrospectively from the claims system through claims data analysis and data review activities. Referrals may also be made as part of the new enrollee health screening outreach process that occurs within 90 days of the effective date of enrollment.
Essential functions of a BMA case manager include the following:

Assessment: The case manager collects and analyzes data about actual and potential member needs. This may involve gathering data in relation to the member's medical issues, cognitive status, and functional status. After the data is analyzed, there is the planning, implementing and evaluation of the case management plan.

Planning: The case manager develops a member centered case management plan. This plan is developed in conjunction with the physician and specifies goals that meet the benefit needs of the member in the best way possible. This means identifying both short and long-term goals. It is essential that the case manager understand the benefits contained in the member's plan in order to formulate a case management plan.

Linking/coordination: The case manager helps ensure continuity of care and integration of benefits across a variety of settings. Coordination is achieved through communication with the member, family and providers. The case manager may also coordinate with existing community-based programs and services. Case management will also address the multidimensional benefit needs of the individual member to help promote continuity of care.

Monitoring/evaluation: Case management will monitor interventions, based upon benefits, to help make sure that they are in accordance with the case management plan and that they are effective. Revisions will be made as needed. If these goals are not being met then the case manager should work with the member to modify the plan for the member.

Advocacy: The case manager should incorporate the member's needs and goals in the plan. Case managers should gather input from all relevant parties to help ensure continuity of benefits so that the member will achieve optimal results. Case managers are required to help protect the privacy and confidentiality of members at all times. Case managers should also present their limitations due to potential conflicts of interest between the member and BMA.

3.19 Stars Outbound Call (OBC) Program

The Medicare Advantage Stars Outbound Call (OBC) Program plays a key role in addressing the BMA approach for Medicare Advantage members in improving their health by getting the quality of care they need at the right time and in the right setting through conducting an outbound call to members and/or providers to communicate the importance of obtaining preventive services such as colorectal screening, mammograms, annual wellness visits, and retinal eye exams.

By closing members' gaps in care, this will help improve member health outcomes. Focused questioning by our Patient Education Coordinators (PEC), pharmacists, and technicians address key clinical measures to ensure our members receive the right care at the right time.

This program allows members to be proactively involved in their own care by notifying them of preventive screenings that can detect and help prevent chronic illness and highlighting the potential benefit of the proactive behavior. Focused scripting and call messaging allows for barrier assessment and provides actionable messaging aligned with behavior change. Members with barriers to care are offered assistance with transportation coordination, financial needs, or provided access to community resources within their respective area. Care coordination is offered along with referrals to a pharmacist, nurse, or social worker to address any issues or to receive assistance with scheduling recommended care.

3.20 Under and Over Utilization

BMA has established measures to detect potential under and over utilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed.

BMA does not compensate, reward or give incentives, financially or otherwise, to its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision making for the

Blue Medicare Advantage plans is based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

3.21 Readmission Review Process

Readmission

For all services reimbursed by a DRG Rate or Case Rate, a readmission within 30 days of the discharge of the first admission for a related diagnosis or procedure, a complication arising out of the first admission, a readmission for services that should have been rendered during the previous admission, or a premature discharge is considered part of the original admission for reimbursement.

The specific situations for which the readmission payment may be considered part of the original admission for reimbursement are:

- Member is discharged before all medical treatment is rendered. Care during the second admission should have occurred during the first admission.
- Member is discharged without discharge criteria being met, including the clinical and level of care criteria.
- Member is discharged from the hospital after surgery, but is readmitted within 30 days. The standards of care for evaluating the patient for known complications are not documented in the record. The readmission is due to a direct or related complication from the surgery.
- Member discharged from the hospital with a documented plan to readmit within 30 days for additional services (doctor requested, member requested).
- Member is discharged to allow resolution of a medical problem that, unless resolved, is a contraindication to the medically necessary care that will be provided during the second admission.
- Member is discharged meeting discharge criteria but nonclinical factors have not been addressed, and member has had previous 30-day admits. Member has issues or barriers that require discharge plans beyond the typical.

If a subsequent admission is reimbursed at a methodology other than a DRG or Case Rate (in other words, Per Diem Rate or %age Rate), then BMA shall only reimburse the facility for the DRG or Case Rate of the original admission. None of these scenarios shall be combined to qualify for outlier reimbursement, if applicable. If facility is an acute care hospital and is part of a hospital system operating under the same *Facility Agreement*, and/or if the facility shares the same tax identification number with one or more acute care hospitals, then a readmission during the same 30-day period to another acute care hospital within the system, and/or another acute care hospital operating under the same tax identification number as the facility, shall be subject to this readmission provision.

3.23 BMA Care Transition Protocols and Management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between healthcare providers and settings and include changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between healthcare professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes

both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing healthcare management with the goal of providing access to high-quality, cost-effective medical care.

Personnel Responsible for Coordinating Care Transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are protocols when managing transitions:

- Participate in the interdisciplinary care team meetings.
- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member about the transition process.
- Communicate health status and plan of care to the member.
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- Provide relevant patient history to the receiving provider.
- Forward pertinent diagnostic results to treating providers.
- Communicate any test results and the treatment plan back to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member's care needs as identified during case management or model of care activities.
- Assist the member in making appointments.
- Coordinate between Medicaid and Medicare benefits.
- Perform medication reconciliation.
- Arrange transportation.
- Refer the member to external or internal programs.
- Coordinate care with behavioral health services.
- Assist with arranging DME and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease-specific education and self-management techniques.
- Contact high-risk members post-discharge to reduce unnecessary readmissions.
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition.

4 BLUE MEDICARE ADVANTAGE PROVIDER PAYMENT DISPUTES, ADMINISTRATIVE PLEAS, AND STANDARD APPEALS

4.1 Distinguishing between Provider and Medicare Advantage Member Appeals

BMA has separate and distinct processes for requests to reconsider a BMA decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare member liability denials are subject to the Medicare Complaints, Appeals and Grievances (MCAG) process as outlined in the *Medicare Member Liability Appeals* and *Medicare Member Grievance* sections of this Provider Manual. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare member follow the Blue Medicare Advantage participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with BMA and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow BMA to make an expedited decision. Your participation in and the member's election of the Medicare Advantage plan are an indication of consent to release those records as part of healthcare operations.

Medicare Member Liability

BMA has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or are considered Medicare member cost share. Any time a member liability denial letter is issued, the member appeals process must be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice* (*IDN*) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*.
- The *Notice of Denial of Medicare Prescription Drug Coverage* is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*.
- A decision that inpatient hospital care is no longer necessary with delivery of the *Important Message from Medicare (IM)* as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*
- A *Notice of Medicare Non-Coverage* (*NOMNC*) is delivered as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits* (*EOB*) indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability

If BMA has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment, the participating provider is prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability
BMA has determined that the nonparticipating provider failed to follow Medicare requirements unless the plan has determined member liability and issued the appropriate notices as above and has procedures for the nonparticipating provider to follow.

4.2 Provider Claim Payment Disputes and Administrative Plea Processes

Provider Claim Payment Dispute process
If you disagree with the outcome of a claim, you may begin the provider payment dispute process. Provider Payment Disputes and Provider Administrative Pleas are different processes:

- **Provider Payment Dispute**: The claim has been finalized but you disagree with the amount that you were paid;
- **Provider Administrative Plea**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- Claim Inquiry: A question about a claim, but not a request to change a claim payment.
- Claims Correspondence: When BMA requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials are in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous BMA decision where medical necessity was not established and provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this provider manual.

The BMA provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute and no action is required by the member.

1. Claim Payment Reconsideration: This is first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. Claim Payment Appeal: The second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal. Claim Payment Appeals must be submitted in writing or via the web and should explain the basis for disputing the outcome of the Claim Payment Reconsideration.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.

- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

*Timely filing issues: BMA will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

4.3 Claim Payment Reconsideration

The first step in the BMA claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider web portal within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 days from the *EOP* will considered to be untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly; however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claims payment reconsideration within 45 calendar days of receipt.

We will send you our decision in a determination letter when upholding our decision, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action the plan intends to take or has taken.
3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider’s right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the claim payment appeal process is a necessary requirement before requesting a state fair hearing (where applicable).

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately. Overturned decisions will result in an adjustment and EPOs.

4.4 Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 63 calendar days of the date on the reconsideration determination letter. Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claim payment appeal within 30 calendar days of receipt.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

4.5 How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services.
    - **Online (for reconsiderations and claim payment appeals):** Use the secure provider Availity Appeal application at **Availity.com**. For Appeals, your Availity Essentials user account will need the Claim Status role. To Send Attachments from Claim Status, you'll need the Medical Attachments role.
    - Locate the claim you want to dispute on Availity using **Claim Status** from the **Claims & Payments** menu. If available, select **Dispute Claim** to initiate the dispute. Go to **Request**" to navigate directly to the initiated dispute in the appeals dashboard add the documentation and submit.
- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:
    - Provider Payment Disputes
      P.O. Box 61599
      Virginia Beach, VA 23466-1599

Required Documentation for Claims Payment Disputes

The health plan requires the following information when submitting a claim payment dispute (reconsideration or claim payment appeal):

- Your name, address, phone number, email, and either your NPI or TIN.
- The member's name and their Medicaid or Medicare ID number.
- A listing of disputed claims, which should include the claim number and the date(s) of service(s).
- All supporting statements and documentation.

Claim Inquiry

A question about a claim or claim payment is called an inquiry. Inquiries do not result in changes to claim payments, but outcome of the claim inquiry may result in the initiation of the claim payment dispute. In

other words, once you get the answer to your claim inquiry, you may opt to begin the claim payment dispute process.

Claim status online

Providers can confirm the status and payment detail of their claims by logging in to **Availity Essentials** with their username and password.

When viewing the status of a claim on Availity, there may be options available to submit medical records or an itemized bill or dispute the claim.

Our Provider Experience program helps you with claim inquiries. Call Provider Services and select the Claims prompt within our voice portal. We connect you with a dedicated resource team, called the Provider Service Unit (PSU), to ensure:

- Availability of helpful, knowledgeable representatives to assist you.
- Increased first-contact, issue resolution rates.
- Significantly improved turnaround time of inquiry resolution.
- Increased outreach communication to keep you informed of your inquiry status.

The PSU is available to assist you in determining the appropriate process to follow for resolving your claim issue.

Claim Correspondence

Claim correspondence is different from a payment dispute. Correspondence is when the plan requires more information in order to finalize a claim. Typically, Blue Medicare Advantage makes the request for this information through the *EOP*. The claim or part of the claim may, in fact, be denied, but it is only because more information is required to process the claim. Once the information is received, BMA will use it to finalize the claim.

The following table provides examples the most common ccorrespondence issues along with guidance on the most efficient ways to resolve them.

Type of Issue	What Do I Need to Do?
EOP Requests for Supporting Documentation (*Sterilization/ Hysterectomy/Abortion Consent Forms*, itemized bills and invoices)	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the supporting documentation to: Claims Correspondence Blue Medicare Advantage P.O. Box 61010 Virginia Beach, VA 23466-1010.
EOP Requests for Medical Records	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the medical records to: Claims Correspondence Blue Medicare Advantage P.O. Box 61010 Virginia Beach, VA 23466-1010.
Need to submit a Corrected Claim due to errors or changes on original submission	Submit a *Claim Correspondence Form* and your corrected claim to:

Type of Issue	What Do I Need to Do?
	Claims Correspondence Blue Medicare Advantage P.O. Box 61010 Virginia Beach, VA 23466-1010. Clearly identify the claim as corrected. We cannot accept claims with handwritten alterations to billing information. We will return claims that have been altered with an explanation of the reason for the return. Provided the claim was originally received timely, a corrected claim must be received within 365 days of the date of service. In cases where there was an adjustment to a primary insurance payment and it is necessary to submit a corrected claim to BMA to adjust the other health insurance (OHI) payment information, the timely filing period starts with the date of the most recent OHI *EOB*.
Submission of coordination of benefits (COB)/third-party liability (TPL) information	Submit a *Claim Correspondence Form*, a copy of your *EOP* and the COB/TPL information to: Claims Correspondence Blue Medicare Advantage P.O. Box 61010 Virginia Beach, VA 23466-1010.
Emergency Room Payment Review	Submit a Claim Correspondence form, a copy of your EOP and the medical records to: Claims Correspondence Blue Medicare Advantage P.O. Box 61010 Virginia Beach, VA 23466-1010.

5 BLUE MEDICARE ADVANTAGE PARTICIPATING PROVIDER STANDARD APPEALS

5.1 Participating Provider Standard Appeals

BMA participating providers may initiate provider appeals under the provider appeal procedures. BMA typically determines provider appeals within 60 days when sufficient information is received to make a decision.

5.2 Medicare Participating Provider Standard Appeal

A formal request for review of a previous BMA decision where medical necessity was not established and provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility

All requests must be:

- Submitted in writing.
- Submitted within 180 days from the BMA decision letter date.*
- Include a cover letter with:
  - Member identifiable information
  - Date(s) of service in question
  - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute BMA's original decision
- Include necessary attachments:
  - Copy of the original BMA decision
  - All applicable medical records

N**ote**: BMA will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Mail to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the BMA Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirements.

InterPlan Medicare Advantage Program policies may be applied to properly submitted Network Provider Appeals of previously adjudicated Inter-Plan Claims.

6 BLUE MEDICARE ADVANTAGE NONPARTICIPATING PROVIDER PAYMENT DISPUTES AND APPEALS

6.1 Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process. For more information regarding the disputes process, please see **Claims Dispute** section.

6.2 Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment with member liability (see original decision letter), the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability Statement* must be included. To obtain this form, visit **cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip**

The purpose of the *Waiver of Liability Statement* is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address.
Medicare Complaints, Appeals & Grievances
Attention: Non-Contracted Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

7 BLUE MEDICARE ADVANTAGE MEMBER COMPLAINTS, APPEALS AND GRIEVANCES

7.1 Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and the Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Therefore, it is important for the physician to be aware of the difference between appeals and grievances.

7.2 Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants BMA to reconsider and change an initial coverage/organization determination (by BMA or a provider) about what services, benefits or prescription drugs are necessary or covered or whether BMA 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 BMA 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 BMA or a provider concerning authorization for or termination of coverage of a healthcare service
- An adverse initial organization determination by BMA concerning reimbursement for a healthcare service
- An adverse initial organization determination by BMA 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
- An adverse coverage determination by BMA or a provider concerning authorization or payment for prescription drugs

Appeals should be sent to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

7.3 Participating Provider Responsibilities in the Medicare Member Appeals Process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an *Appointment of Representative*

Form may be required. The *Appointment of Representative Form* can be found online and downloaded at **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.
- Standard Part C pre-service appeals that are not for a Part B drug, must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe.
    - 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 are resolved within 72 hours, unless it is in the member's interest to extend this time period.
    - A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
    - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
    - Part D payment appeals must be resolved within 14 days from the date the request was received.
    - Part D appeals timeframes cannot be extended.

7.4 Further Appeal Rights

If BMA is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- BMA will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
    - Within 72 hours if expedited.
    - Within 30 days if the appeal is related to authorization for healthcare that is not a Part B drug.
    - Within 7 days if the appeal is related to authorization of a Part B drug.
    - Within 60 days if the appeal involves reimbursement for care.
    - Part D prescription drug appeals are not forwarded to the IRO by BMA but may be requested by the member or representative; information will be provided on this process during the Blue Medicare Advantage member appeals process.
- If the IRO 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.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, BMA continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

7.5 Medicare Member Grievances

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with BMA or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

BMA must accept grievances from members orally or in writing within 60 days of the event. BMA must make a decision and respond to the grievance within 30 days. A member can request an expedited grievance, in which case BMA has 24 hours to respond. An expedited grievance can only be initiated if BMA refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). BMA can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

7.6 Resolving Medicare Member Grievances

If a Medicare member has a grievance about Blue Medicare Advantage, a provider, or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

8 REIMBURSEMENT REQUIREMENTS AND POLICIES

Reimbursement policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's BMA benefit plan. These policies can be accessed on the provider site here. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. Covered services do not guarantee reimbursement unless specific criteria are met.

You must follow proper billing and submission guidelines, including using industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes which indicate the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a non-contracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Blue Medicare Advantage:

- Reject or deny the claim
- Recover and/or recoup claim payment
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed

BMA reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, BMA strives to minimize these variations.

8.1 Reimbursement Hierarchy

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodology are considered to be conditions of payments.

8.2 Review Schedules and Updates

Reimbursement policies undergo reviews for updates to state contracts, federal or CMS requirements and/or BMA business decisions. We reserve the right to review and revise our policies when necessary. Reimbursement policies go through a review every two years for updates to state, federal or CMS contracts and/or requirements. When there is an update we will publish the most current policy on the provider website at the link above.

8.3 Medical Coding

The Medical Coding department ensures that correct coding guidelines have been applied consistently throughout BMA. Those guidelines include, but are not limited to:

- Correct modifier use.
- Effective date of transaction code sets (CPT, HCPCS, ICD diagnosis/procedures, revenue codes, etc.)
- Code editing rules are appropriately applied and within regulatory requirements.
- Analysis of codes, code definition and appropriate use.

8.4 Reimbursement by Code Definition

BMA allows reimbursement for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections, unless otherwise noted by state or provider contracts, or state, federal or CMS requirements. There are eight CPT sections:

1. Evaluations and management
2. Anesthesia
3. Surgery
4. Radiology (nuclear medicine and diagnostic imaging)
5. Pathology and laboratory
6. Medicine
7. Category II codes: supplemental tracking codes that can be used for performance measurement
8. Category III codes: temporary codes for emerging technology, services or procedures

8.5 Blue Medicare Advantage Coordination of Benefits

BMA and its providers agree Medicare coverage is secondary and the Medicaid program is the payer of last resort when third-party resources are available to cover the costs of medical services provided to Medicare members. When BMA is aware of third-party resources prior to paying for a medical service, it will follow appropriate coordination of benefits standards by either rejecting a provider's claim and redirecting the provider to bill the appropriate insurance carrier or, if BMA does not become aware of the resource until sometime after payment for the service was rendered, by pursuing post payment recovery of the expenditure. Providers must not seek recovery in excess of the applicable Medicare and/or Medicaid payable amounts.

BMA will follow appropriate coordination of benefits standards for trauma-related claims where third-party resources are identified prior to payment. Otherwise, BMA will follow a pay and pursue policy on prospective and potential subrogation cases. Paid claims are reviewed and researched postpayment to determine likely cases based on information obtained through communications with members and providers. BMA handles the filing of liens and settlement negotiations both internally and externally via its vendors.

The information contained in this handbook should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for BMA members and enrollees are the responsibility of providers and practitioners. Please encourage the patient to review his/her Policy or Evidence of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment, as this Handbook does not supersede the Policy or Evidence of Coverage and Schedule of Benefits. The information in this Handbook may change from time to time.

9 PROVIDER DIGITAL ENGAGEMENT

9.1 Purpose

The purpose of this provider digital engagement chapter is to establish the standards to increase utilization of secure digital provider tools and applications that are accessible to participating and non-participating providers to improve efficiencies for providers and BMA. This chapter is applicable medical, dental and vision services.

In support of this digital supplement, the following efficiencies have been documented as industry averages per the annual CAQH CORE Efficiency Index study:

Table 10: Average, Minimum, and Maximum Time Spent by Providers Conducting Manual, Partial and Electronic Transactions, Medical, 2019 CAQH Index

Transaction	Method	Average Time Providers Spend per Transaction (minutes)	Min Time Providers Spend per Transaction (minutes)	Max Time Providers Spend per Transaction (minutes)	Potential Average Time Saving (minutes)
Eligibility and Benefit Verification	Manual	10	3	30	8
	Partial	5	1	15	3
	Electronic	2	<1	10	
Prior Authorization	Manual	21	3	45	17
	Partial	8	1	20	4
	Electronic	4	<1	18	
Claim Submission	Manual	6	1	25	4
	Electronic	2	<1	6	
Attachments	Manual	11	1	30	6
	Electronic	5	1	10	
Claim Status Inquiry	Manual	12	1	20	8
	Partial	4	1	10	0
	Electronic	4	<1	11	
Claim Payment	Manual	5	<1	11	2
	Electronic	3	<1	10	
Remittance Advice	Manual	7	<1	19	5
	Partial	4	<1	10	2
	Electronic	2	<1	10	
Total Potential Time Savings (Manual)					**50**
Total Potential Time Savings (Partial)					**9**

9.2 Supplement Statement

This Supplement outlines the digital tools BMA has available to providers who serve its members, whether par or non-par. It is BMA's expectation that providers will utilize these digital tools unless mandated by law or other legal requirement no later than January 1, 2021. The electronic tools and applications include the secure Provider Portal, Electronic Data Interchange (EDI) Transaction Gateway and available Business-to-Business Application Programming Interfaces (B2B APIs) - all hosted via Availity. This Supplement addresses the following processes:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, attachments and authorization status
- Claim submission, including attachments and claim status
- Remittances and payments

It is preferred, that in markets where these tools are currently available, these digital alternatives are used:

- Disputes
- Grievances and Appeals
- Demographic updates
- Pharmacy Prior Authorization drug requests
- Services through BMA affiliates, Carelon Medical Benefits Management and Carelon Medical Benefits Management
- Provider Enrollment

BMA expects that all providers seeking any functions and processes above will use available electronic self-service tools including EDI X12 transactions, the secure Provider Portal or direct desktop integration via B2B APIs in lieu of manual channels (paper, mail, fax, call, etc.). Availity provides access to all BMA self-service tools across all electronic channels outlined above. All digital channels are consistent with industry standards.

Access to all BMA digital tools and capabilities is available on Availity **Availity.com**. Please access Availity to learn more about available EDI, Portal and B2B API options. Administration Simplification standard transaction requirements: **hhs.gov/hipaa/for-professionals/other-administration-simplification-rules/index.html**

NOTE: As a mandatory requirement, all trading partners who currently transmit directly to a BMA EDI Gateway must transition to the Availity EDI Gateway and have an active Availity Trading Partner Agreement in place.

9.3 Acceptance of Digital ID Cards

As BMA's members transition to using electronic member identification cards, providers may need to implement changes in their processes to accept this new format. BMA expects that providers will accept the electronic version of the member identification card in lieu of a physical member identification card. If providers require a copy of a physical member identification card, mmembers can fax or email a copy of the electronic member identification card from their phone/app, or providers can access it directly through Availity.

9.4 Eligibility and benefit inquiry and response

Providers may leverage any of the following Availity-hosted channels for electronic Eligibility & Benefit inquiry and response:

- EDI Transaction: X12 270/271 Eligibility Inquiry and Response (version 5010)

    - BMA supports the industry standard X12 270/271 transaction set for eligibility and benefit inquiry and response as mandated by *HIPAA*.
- Availity Essentials
- To verify member eligibility, log on to Availity at **Availity.com**. From Availity's homepage, select **Patient Registration > Eligibility & Benefits**.
- Provider desktop integration via B2B APIs
    - BMA has also enabled real-time access to Eligibility and Benefit verification APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration opportunities at **Availity.com/Healthcare-APIs**.

9.5 Authorizations

Prior Authorization Submission, Attachment and Status

Providers may leverage any of the following channels for Prior Authorization submission, status inquiries and submission of electronic attachments (solicited or unsolicited) on Availity:

- EDI Transaction: X12 278 Prior Authorization and Referral (version 5010)
    - BMA supports the industry standard X12 278 transaction for prior auth submission and status inquiry as mandated per HIPAA.
- EDI Transaction: X12 275 Patient Information including HL7 payload (version 5010) for authorization attachments
    - BMA supports the industry standard X12 275 transaction for electronic transmission of supporting authorization documentation including medical records via the HL7 payload.
- Availity Essentials
    - Interactive Care Reviewer (ICR) – The authorization ICR utility allows a provider to key a prior authorization request including an attachment or status inquiry directly into an online form.
    - Additionally, providers can use ICR to make inquiries on previously submitted requests regardless of how the original prior authorization was submitted (phone, fax, eReview, secure email, etc.).
- Provider desktop integration via B2B APIs
    - BMA has also enabled real-time access to Prior Authorization APIs that can be directly integrated within participating vendors' practice management software, revenue cycle management software and some electronic medical records software. Contact Availity for available vendor integration at **Availity.com/Healthcare-APIs**.

9.6 Electronic Data Interchnage Claim Submission

Electronic Data Interchange (EDI)

Blue Medicare Advantage uses Availity as its exclusive partner for managing all electronic data interchange (EDI) transactions. Electronic Data Interchange (EDI), including Electronic Remittance Advices (835) allows for a faster, more efficient and cost-effective way for providers and employers to do business.

Availity's EDI submission Options

- EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software). To register for direct EDI transmissions, visit – **Availity.com** > Provider Solutions > EDI Clearinghouse.
- Use your existing vendor for your EDI transactions (work with your vendor to ensure connection to the Availity EDI Gateway)

Use Availity for the following EDI transactions:

- Healthcare Claim: Professional (837P)
- Healthcare Claim: Institutional (837I)
- Healthcare Claim: Dental (837D)
- Healthcare Eligibility Benefit Inquiry and Response (270/271)
- Healthcare Services Prior Authorization (278)
- Healthcare Services Inpatient Admission and Discharge Notification (278N)
- Healthcare Claim Payment/Advice (835)
- Healthcare Claim Status Request and Response (276/277)
- Medical Attachments (275)

EDI Response Reports

Claims submitted electronically will return response reports that may contain rejections. If using a Clearinghouse or Billing Vendor, please work with them to ensure you are receiving all reports. It's important to review rejections as they will not continue through the process and require correction and resubmission. For questions on electronic response reports contact your Clearinghouse or Billing Vendor or Availity at 800- AVAILITY (800-282-4548).

Availity Payer ID 54704

Availity's Payer ID's
apps.availity.com/public-web/payerlist-ui/payerlist-ui/#/

Note: *If you use a clearinghouse, billing service or vendor, please work with them directly to determine payer ID.*

Useful EDI Documentation

Availity EDI Connection Service Startup Guide - This guide includes information to get you started with submitting Electronic Data Interchange (EDI) transactions to Availity, from registration to on-going support.

Availity EDI Companion Guide - This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity.
Availity Registration Page - Availity register page for users new to Availity.
Washington Publishing Company - X12 code descriptions used on EDI transactions.

9.7 Electronic Remittance Advice (835) & Electronic Funds Transfer (EFT)

Like the payroll direct deposit service that most businesses offer their employees, Electronic Funds Transfer (EFT) uses the Automated Clearing House (ACH) Network to transmit healthcare payments from a health plan to a healthcare provider's bank account. Health plans can use a provider's banking informaton only to deposit funds, not to withdraw funds. BMA expects providers to accept payment via Electronic Funds Transfer (EFT) in lieu of paper checks. Visit **provider.bluemedadv.com** under EDI for EFT registration instructions. This tool will help eliminate the need for paper registration, reduce administrative time and costs and allows physicians and facilities to register with multiple payers at one time. EFT payments are deposited faster and are generally the lowest cost payment method.

To facilitate quicker reimbursement for providers who have not enrolled for EFT, Blue Medicare Advantagey move paper checks to a virtual card payment method. Virtual cards allow physicians and facilities to process payments as credit card transactions.

Electronic Remittance Advice (ERA) (835)
The 835 eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to **Availity**
2. Select **My Providers**
3. Click on **Enrollment Center** and select **Transaction Enrollment**

Note: *If you use a clearinghouse or vendor, please work with them on ERA registration and receiving your ERA's.*

Contact Availity
Please contact Availity Client Services with any questions at **800-AVAILITY (800-282-4548)**

10 FRAUD, WASTE AND ABUSE DETECTION

BMA is committed to protecting the integrity of BMA's healthcare programs and the effectiveness of operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud:** Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person committing it -- or any other person. The attempt itself is fraud, regardless of whether or not it is successful
- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** When health care providers or suppliers do not follow good medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

One of the most important steps to help prevent Member fraud is as simple as reviewing the Member identification card to ensure that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **fighthealthcarefraud.com**.

10.1 Reporting Fraud, Waste and Abuse

If someone suspects any Member or provider (a person who receives benefits) has committed fraud, waste or abuse, they have the right to report it. No individual who reports violations or suspected fraud and abuse will be retaliated against for doing so. The name of the person reporting the incident and his or her callback number will be kept in strict confidence by investigators.

Report concerns by:

- Visit **provider.bluemedadv.com**, scroll to the bottom footer and select **Health Care Fraud Prevention** to be directed to the **fighthealthcarefraud** education site; at the top of the page, select **Report it** and complete the **Report Waste, Fraud and Abuse** form
- Calling Provider Solutions.

Any incident of fraud, waste or abuse may be reported to BMA anonymously; however, BMA's ability to investigate an anonymously reported matter may be limited if BMA doesn't have enough information. BMA encourages Providers and Facilities to give as much information as possible. BMA appreciates referrals for suspected fraud, but be advised that BMA do not routinely update individuals who make referrals as it may potentially compromise an investigation.
Examples of Member Fraud, Waste and Abuse

- Forging, altering or selling prescriptions
- Letting someone else use the Member's ID (Identification) card
- Obtaining controlled substances from multiple providers
- Relocating to out-of-service Plan area
- Using someone else's ID card

When reporting concerns involving a Member include:

- The Member's name
- The Member's date of birth, Member ID or case number if available
- The city where the Member resides
- Specific details describing the fraud, waste or abuse

Examples of Provider Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures which should be covered by a single comprehensive procedure code
- Upcoding – when a provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

When reporting concerns involving a provider (a doctor, dentist, counselor, medical supply company, etc.) include:

- Name, address and phone number of provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the provider and facility, if available
- Type of provider (doctor, dentist, therapist, pharmacist, etc.)
- Names and phone numbers of other witnesses who can help in the investigation
- Dates of events
- Summary of what happened

To learn more about health care fraud and how to aid in the prevention on it, visit **fighthealthcarefraud.com**.

10.2 Investigation Process

The Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. BMA may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education:* BMA sends letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- *Medical record review:* BMA reviews medical records to investigate allegations or validate the appropriateness of Claims submissions.
- *Edits:* A certified professional coder or investigator evaluates Claims and places payment or system edits in BMA's Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- *Recoveries:* BMA recovers overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

10.3 Prepayment Review

One method BMA uses to detect FWA is through prepayment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to BMA's attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to BMA's attention for reasons mentioned above, further review may be conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or

billing practices. If the review results in a determination that the Provider's or Facility's actions may involve FWA, unless exigent circumstances exist, the Provider or Facility is notified of their placement on prepayment review and given an opportunity to respond.

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so BMA can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to BMA in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, BMA may review coding, documentation, and other billing issues. In addition, BMA may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan Members.

The Provider or Facility will remain subject to the prepayment review process until BMA is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

Finally, Providers and Facilities are prohibited from billing a Member for services BMA has determined are not payable as a result of the prepayment review process, whether due to FWA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

10.4 Acting on Investigative Findings

In addition to the previously mentioned actions, BMA may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies.

10.5 Recoupment/Offset/Adjustment for Overpayments

BMA shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by BMA to Provider or Facility ("Overpayment Amount") against any payments due and payable by BMA or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any Agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by BMA that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to BMA within thirty (30) calendar days of the date of the overpayment refund notice from BMA to the Provider or Facility. If the Overpayment Amount is not received by BMA within the thirty (30) calendar days following the date of such notice letter, BMA shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by BMA or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall

be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by BMA or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under BMA's procedures set forth in the Provider Manual, provided that such appeal shall not suspend BMA's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. BMA reserves the right to employ a third-party collection agency in the event of non-payment.

Blue Medicare Advantage