2023 Manual

Kansas Preferred Blue Medicare Advantage Manual

BlueCross BlueShield Kansas

bcbsks.com

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NOTE — The revision date appears in the footer of the document. Links within the document are updated as changes occur throughout the year.

Chapter 1: Overview

Blue Cross and Blue Shield of Kansas, Inc. Blue Medicare Advantage (Blue MA) is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage (Part C) and Part D prescription drug insurance plans in the senior market. Blue MA will offer Kansas Preferred Blue Medicare Advantage (KPBMA) coverage to Medicare-eligible Kansas residents in the following counties: Butler, Chase, Coffey, Cowley, Dickinson, Douglas, Franklin, Geary, Harvey, Jackson, Jefferson, Kingman, Linn, Lyon, Marion, McPherson, Miami, Morris, Osage, Pottawatomie, Reno, Riley, Sedgwick, Shawnee, Sumner, and Wabaunsee.

Blue MA plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue MA to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit.

Disclaimer

Blue MA makes no representations or warranties with respect to the content hereof. Further, Blue MA reserves the right to revise this publication without obligation to notify any person of such revision or changes.

Updates to any part of this manual may be made by Blue MA or CMS at any time. Either Blue MA or CMS may give notice of such updates in a variety of ways, depending on the nature of the update, including issuance of a letter to providers, publication in provider newsletters or other publications of Blue MA or CMS, or posting to either the Blue MA website, https://www.bcbsks.com/, or the CMS website, www.cms.gov or through other forms of CMS-approved communications.

Blue MA is a Preferred Provider Organization (PPO) plan that includes a network of doctors, other health care providers, and hospitals. In a PPO, members pay less if utilizing doctors, hospitals, and other health care providers that belong to the plan's network. The flexibility to go to doctors, specialists, or hospitals that are not in the plan's network exists, but it usually costs more. Additionally, our PPO BlueCard Travel Program enables members traveling in certain states to use the networks of other participating Blue Cross MA PPO plans.

Note – This Manual is provided for the convenience of providers participating in the KPBMA network. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs, or supplies. Coverage or no coverage is always governed exclusively by the terms of the member's health benefit plan. Accordingly, in case of any question or doubt about coverage, providers should always review the member's particular health benefit plan.

Chapter 2: General Information

The table below provides important contact numbers to assist providers.

Provider Services and Requests for Organization Determinations			
	Phone	**Fax**	**Hours of Operation**
Provider Services	800-240-0577	800-976-2794	8 a.m. – 6 p.m. Monday-Friday
Host Member Claim Inquiries	800-432-3990	785-290-0711	7 a.m. – 4:30 p.m. Monday- Friday
Prior Authorization			
	Phone	**Fax/Web Address**	**Hours of Operation**
Prior Authorization Program	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
New Directions Behavioral Health	877-589-1635	https://webpass.ndbh.com/	
Utilization Management and Care Transition			
	Phone	**Fax**	**Hours of Operation**
Utilization Management/ Care Transition	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
After Hours	800-331-0192	877-218-9089	6 p.m. – 8 a.m. Monday-Friday; 24 hours Saturday-Sunday

Helpful Reminders

In an effort to assist provider offices in obtaining proper eligibility, coverage and benefits information regarding Blue MA members, a list of helpful reminders is provided below:

- When a member calls to schedule an appointment, please ask about insurance information.
- When a member arrives at your office, please ask to see their Blue MA identification card.
- Maintain a current copy of the front and back of the member's identification card in their medical file.
- When possible, collect any copayments, co-insurance, and deductibles the day services are rendered.
- File claims with Blue MA within 365 days even if Blue MA is not the primary payor.

If a member does not have a valid identification card, providers may call our Customer Service department or log into Availity and select the Blue MA payor space to access the in the most current membership eligibility information available for Blue MA members.

Monitoring Utilization

Blue MA uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure that Blue MA members receive the medical services required for health promotion, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of Healthcare Effectiveness Data and Information Set (HEDIS) data
- Results of member satisfaction surveys
- Rate of inpatient admissions
- Rate of emergency services
- Review of alternative levels of care such as observation

Affirmation Statement

Blue MA bases its utilization decisions about care and service solely on their appropriateness in relation to each member's specific medical condition. Blue MA review staff has no compensatory arrangements that encourage denial of coverage or service. Clinicians employed by Blue MA do not receive bonuses or incentives based on their review decisions. Blue MA bases all clinical review decisions on medical necessity by applying approved clinical criteria and ensures that the care provided is within the limits of the member's plan coverage.

Appropriate Professionals

Blue MA continues to demonstrate its commitment to a fair and thorough utilization decision process by working collaboratively with its participating providers. A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by Blue MA Care Management nurses. It may be necessary for the plan medical director to contact providers for additional information about their patients to assist in making a determination. Providers are encouraged to discuss any decision with a plan medical director by contacting Care Management at 800-325-6201 between 8 a.m. and 6 p.m. Monday through Friday. To contact a plan medical director after normal business hours, providers should call 800-331-0192.

Blue MA Member ID Card

The Blue MA member ID card contains basic information needed to verify eligibility and file claims. The Blue MA member ID card indicates the member is enrolled in either the Blue MA or the Blue MA Comprehensive coverage plan.

Blue Cross and Blue Shield Association – the national organization for all Blue plans – ID cards have a similar look and feel to promote ease of use nationwide.

Providers must use the three-character prefix found on the ID card when submitting paper and electronic claims. The prefix is critical for the electronic routing of claims to the appropriate processing areas, confirming member coverage, and prompt claims payment.

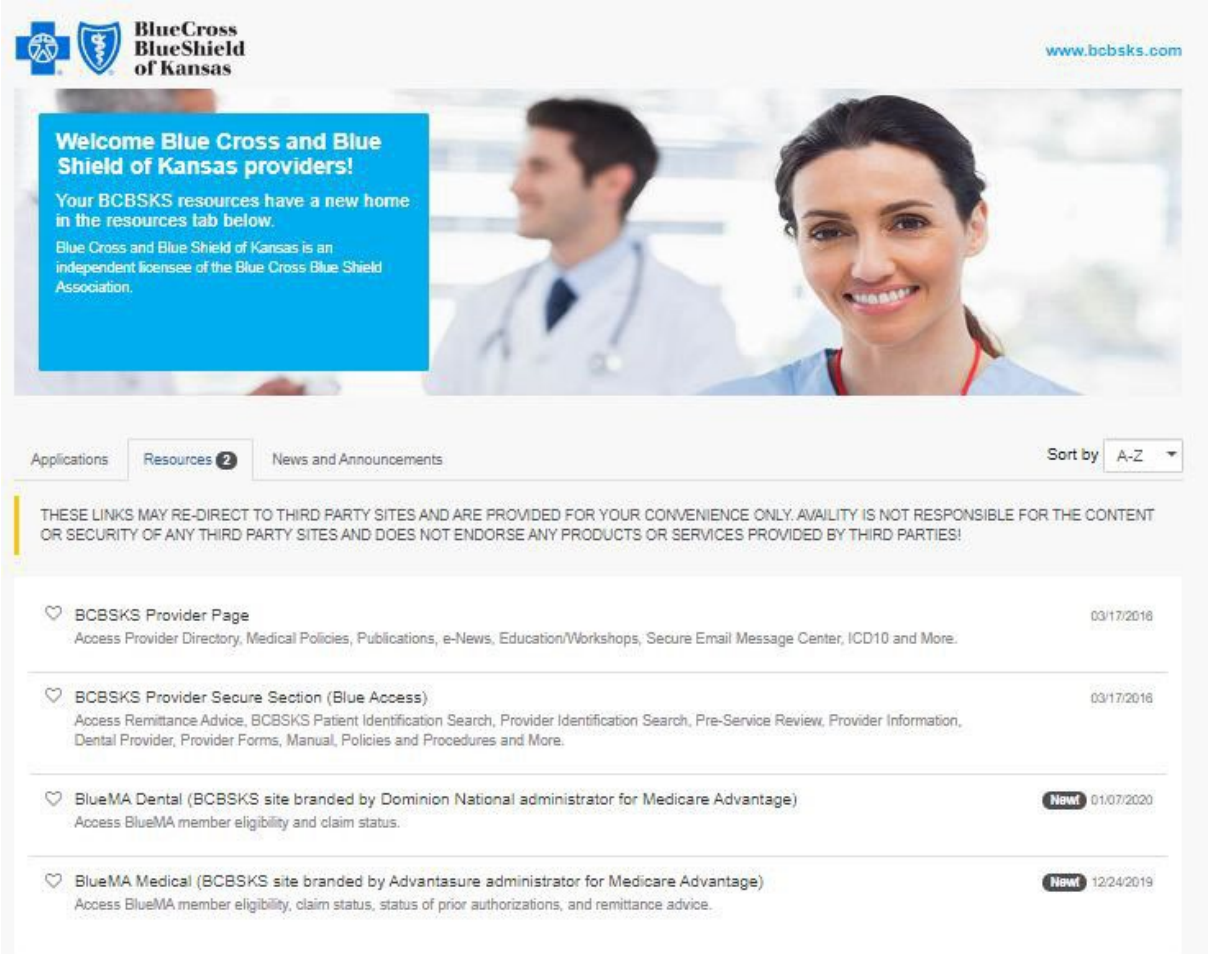
Below is a sample of the members' ID card. The Blue MA member Identification prefix is **M3A**.

The “MA” in the suitcase indicates a member who is covered under the Blue Cross Blue Shield Association BlueCard network sharing program. The sharing program relates to affiliated or contracted BlueCard providers and it allows Blue MA members to obtain in-network benefits when traveling or obtaining services in areas outside of the MA plan. As with other Blue MA products, members should provide their ID cards when requesting services.

Eligibility and Coverage

Each time your patient receives care, check to see if there have been any coverage changes. Ask to see the patient’s Blue MA ID card or acknowledgement letter at each encounter.

To verify eligibility and coverage, go to Availity.com. The resource tab on the Blue MA payor space includes links to the Blue MA Medical portal.



To search eligibility and coverage, click the Eligibility and Benefits heading and enter the First Name, Last Name and Date of Birth, OR the Member ID.

NOTE – If using the Member ID to search, do not include the M3A prefix and add "00" to the end of the ID.

The Blue MA website – https://www.bcbsks.com/providers/medicare-advantage/ contains public information related to MA member benefits, policy papers, provider manual and additional resources to assist providers.

Providers also can call Blue MA Provider Services at 800-240-0577, 8 a.m. to 6 p.m. Monday through Friday.

Verifying Eligibility and Coverage for Out-of-Area Members – Eligibility and cost-sharing amounts for MA BlueCard members may be obtained by calling 800-810-2583.

MA Member Benefits

For basic Medicare benefits, refer to http://www.cms.gov.

Benefits are available in-network and out-of-network for urgent and emergency services only and available in-network and out-of-network using the Blue Cross Blue Shield Association BlueCard providers outside of Kansas but within the USA.

Blue MA plans offer coverage for the following with minimal or no member cost-share:

- Annual Physical Exam Policy
- Benefit Summaries
    - Topeka Region – Blue Medicare Advantage (PPO) & Blue Medicare Advantage Comprehensive (PPO)
    - Wichita Region – Blue Medicare Advantage (PPO) & Blue Medicare Advantage Comprehensive (PPO)
    - All Regions – Blue Medicare Advantage Choice (PPO)
- Blood and Blood Components Policy
- Dental Care Benefit Policy
- Fitness Benefit Policy
- Hearing Care Policy
- Inpatient Hospital Care Policy
- Meal Benefit Policy
- Medical Policy Hierarchy
- Organ Acquisition Costs Policy
- Over-the-Counter Benefit
- Transplant Travel Benefits Policy
- Vision Care Policy
- Worldwide Coverage Emergency Care Policy

Chapter 3: Claim Filing

Blue MA claims, including revisions or adjustments, must be filed within one calendar year from date of service or discharge.

The National Uniform Claim Committee approved a new version of the CMS-1500 Health Insurance Claim Form. Blue MA currently accepts the revised CMS-1500 claim form (version 02/12). Professional claims must be submitted using the revised CMS-1500 Health Insurance Claim Form (02/12).

UB-04 Processing Information

Blue MA relies on the proper coding to process provider claims and adjudicate the member's benefits. The service codes providers select and enter on claims are a representation of the member's treatment. Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation, or other remedial action.

Filing Claims Electronically

Blue MA encourages the submission of claims electronically using the ANSI ASC X12N 837 Health Care Claims transactions. For more information on electronic claim options, please visit https://www.ask-edi.com.

Most Common Errors

The UB-04 claims pass through claim through edits on the front end before they enter the claim system. The most common errors are:

- No Source of Admission Code in Form Locator 15
- No Patient Status Code in Form Locator 17
- No Provider Number in Form Locator 56 & 57

For complete instructions on the UB-04 form, visit the CMS website at www.cms.gov.

UB-04 Claim Data Element Specifications

Information regarding the national uniform billing data element specifications manual as developed by the National Uniform Billing Committee (NUBC) can be found by accessing their web site at www.nubc.org.

Where to submit a claim

Kansas providers should submit electronic claims to BCBSKS and paper claims to:

Blue Cross and Blue Shield of Kansas
Kansas Preferred Blue Medicare Advantage
P.O. Box 239
Topeka, KS 66629

Non-Kansas providers file with the local Blue plan. Please see the Ancillary Claims section of this manual for more information. Report the alpha prefix to ensure correct routing of the claim.

If you have problems submitting claims or have any billing questions, contact our technical billing resources at:

Electronic Claims
Kansas Providers – Contact ASK-EDI at 800-472-6481.
Non-Kansas Providers – Contact your local Blue plan.
Paper Claims
Kansas Providers – Call Blue MA Customer Service at 800-240-0577.
Non-Kansas Providers – Contact your local Blue plan.

If you have questions about claim status or plan payments:

- Log onto Availity, from the BCBSKS payor space, in the resource tab, select the Blue Medicare Advantage link.
- Kansas Providers – Call Blue MA Provider Services at 800-240-0577.
- Kansas Providers for Out-of-State/ITS Host Members – Call Customer Service at 800-432-3990
- Non-Kansas Providers – Contact your local Blue plan.

Ancillary Claims

The Blue Cross Blue Shield Association has rules pertaining to how independent laboratories, durable medical equipment suppliers and specialty pharmacies should submit claims in certain circumstances.

These rules also impact referring providers. Here are highlights:

- Independent labs should file claims with the plan in whose state the specimen was drawn (determined by where the referring provider is located).
- Durable medical equipment suppliers should file claims with the plan in whose state the equipment or supplies were shipped to (including mail order supplies) or purchased (if it was purchased at a retail store).
- Specialty pharmacies should file claims with the plan in whose state the ordering provider is located.

Durable Medical Equipment (DME), Prosthetics and Orthotics (P&O), medical suppliers and pharmacists

Blue Medicare Advantage plans include coverage for medically necessary durable medical equipment, prosthetics and orthotics, medical supplies, and pharmacy; including Part B drugs that are all covered under Original Medicare. For additional details, contact provider services, or reference the Explanation of Coverage at https://www.bcbsks.com/medicare/forms.

DME providers do require credentialing for each DME location/NPI, this includes physicians and non-physician practitioner (NPP) groups providing DME under one billing/type 2 NPI. In addition to the ancillary guidelines above, claims for services listed on the CMS DMEPOS fee schedule should be billed to Blue MA in a manner consistent with Medicare guidelines and local and national coverage articles, including appropriate place of service codes and with appropriate billing and rendering NPIs for the DMEPOS provider.

Rural Health Clinic and Federally Qualified Health Center Billing

If a service is performed at a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) and the service is payable as a RHC or FQHC, the service is billed to Blue MA on a UB-04 form.

If a service is performed at a RHC outside of its CMS all-inclusive rate, the service should be billed on a 1500 form.

The place of service code should represent where the actual service was performed. The following codes are examples of codes RHCs may utilize for the place of service:

- 72 – Rural Health Clinic (RHC) (The service was performed in the RHC facility)
- 32 – Skilled Nursing Facility (SNF)
- 19 or 22 – Outpatient hospital
- 21 – Inpatient hospital

For more information on RHC and FQHC billing guidelines for Medicare beneficiaries, reference the Medicare Claims Processing Manual, Chapter 9, and Pub. 100-02, Medicare Benefit Policy Manual, Chapter 13.

Coordination of Benefits

When Blue MA is the secondary carrier, the benefits will be reduced by the amount paid by the primary carrier. The allowable expense is a service that is covered in full or in part by any of the plans covering the person. Non-covered expenses are not coordinated. We follow all Medicare secondary-payer laws.

Ultimately, it is the member's responsibility to ensure delivery of the Explanation of Benefits (EOB) from the primary carrier to Blue MA. However, if the provider receives the EOB from the primary carrier, he or she may forward it to Blue MA for processing.

When Blue MA is secondary, a provider has the right to collect the copayment, deductible, or coinsurance and then coordinate benefits with the other carrier.

Note – If Blue MA is the secondary payor, providers should not submit a claim until they have received the primary payor's payment.

If the provider receives payment in excess of actual charges and has collected a copayment, deductible or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the copayment, deductible or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

If the provider contractually participates with other health plan(s), the privilege to collect a co-payment may be affected by the agreement with the other health plan(s).

Timely Filing Requirement

Medicare law prescribes specific time limits within which claims for benefits may be submitted. The timely filing period for both paper and electronic Medicare claims, is 365 days after the

date on which the services were provided.

Whenever the last day for timely filing of a claim falls on a Saturday, Sunday, Federal non-workday or legal holiday, the claim will be considered filed timely if it is filed on the next workday.

Advanced Directives

Blue MA plans provide members information on their right to complete an advance directive. Advance directive means a written instruction, recognized under state law, relating to how to provide health care when an individual is incapacitated. As part of the medical record content requirements for Blue MA, providers must document in the medical record of whether a member has or does not have an advance directive. If a member has completed and presents an advance directive, then the provider must include It in the member's medical record.

Claims for Unlisted and Not Otherwise Classified (NOC) Procedure Codes

To ensure timely, accurate and efficient claim processing, supporting documentation should be attached to all Blue Medicare Advantage (MA) claims submitted with an unlisted or NOC procedure code(s), and/or services with modifier 22 appended.

If documentation supporting the service(s) is not included with the claim submission, the claim may deny, and a remark code included on the explanation of payment (EOP) indicating the specific documentation needed. Documentation being submitted in response to a request through a denial code on the EOP may be faxed to 800-976-2794, or mailed to PO Box 260875, Plano, TX 75026. A new claim is not needed when submitting records or documentation requested via a denial code/message on the EOP.

MA claims with attachments should be submitted by postal mail. When submitting claims for NOC codes, the documentation needed is dependent on the type of service performed, refer to the following table for minimum necessary documentation for each type of service:

Unlisted Code Type	Documentation Needed	Examples
Anesthesia Unlisted Service or Procedure	Special report Adequate definition or description of the nature, extent, and need for the procedure - Time - Effort - Equipment necessary to provide service	CPT code 01999: Unlisted anesthesia procedure

Unlisted Code Type	Documentation Needed	Examples
Imaging/Radiology Procedures	- Diagnosis - Imaging report (including test(s) and results of test)	CPT code 76999: Unlisted Ultrasound procedure
Lab/Pathology Procedures	Lab/pathology report (Note, Item 19 of the CMS- 1500 claim form must include the specific name of the lab test(s) and/or a short descriptor of the test(s).)	CPT code 86849: Unlisted immunology procedure
Medical Service or Procedure	Office notes and any reports	CPT code 96999: Unlisted special dermatological service or procedure CPT code 95999: Unlisted neurological or neuromuscular diagnostic procedure
Surgical Procedures	- Description of the extent and need for the procedure - Operative or procedure reports, office notes - Explanation as to why a standard coded - CPT procedure is not appropriate; Comparable CPT/HCPCS service code(s), value in comparable RVU and/or a percentage of a reasonably comparable CPT/C6HCPCS that would reflect services performed.	CPT codes 48999: Unlisted pancreas surgery procedure
Unlisted DME HCPCS Codes	Narrative/description included on claim, including the name of the item, manufacturer and product Number (UPN); If applicable a copy of the invoice.	HCPCS codes A9999: Miscellaneous DME supply or accessory, not otherwise specified E1399: Miscellaneous Durable Medical Equipment (DME)
Unlisted Services for E/M	<u>Special report</u> - Adequate definition or description of the nature, extent, and need for the procedure - Time - Effort - Equipment necessary to provide service Note, additional items may be provided such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems and follow-up care.	CPT code 99499: Unlisted E&M service

Unlisted Code Type	Documentation Needed	Examples
Unclassified/Unlisted Drug Codes	Necessary information needed to process valid unlisted drug codes: • NDC qualifier (N4) • NDC billing number (11-digit billing format, with no spaces, no hyphens and no special characters). If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 54-2 configuration • NDC product package size unit of measure (e.g., UN, ML, GR, F2) • The NDC must be submitted along with the accurate HCPCS/CPT code(s) and the number of HCPCS/CPT units. ○ NDC unit to reflect the quantity of drug product administered. We'll accept up to three decimals in the NDC units (quantity of number of units) field. Failure to include appropriate decimals in the NDC units' field may lead to incorrect payments subject to review or audit. • The NDC must be active for the date of service. • Note: Providers should list one unit of service in the 2400/SVI -04 data element or in item 24G of the CMS 1500 form or in field 46 of the UB-04. Do not quantity bill CPT/HCPCS units for NOC drugs or biologicals even if multiple units are provided unless otherwise directed for specific products. • Note: Claims for unlisted drugs without a	HCPCS codes: J3490: Unclassified drugs J3590: Unclassified biologicals J3590: Unclassified biologicals J7999: Compounded drug, not otherwise classified J9999: Not otherwise classified, antineoplastic drugs C9399: Unclassified drugs or biologicals

Medical Policy Hierarchy

In terms of the sequence of prior authorization review, Blue MA will first reference existing National Coverage Determinations (NCD) or Local Coverage Determinations (LCD). If neither of these exist, Blue MA will reference InterQual criteria (Acute Adult, Subacute/SNF, Long-Term Acute Care Rehabilitation).

Chapter 4: Claims Payment, Refunds, and Offsets
Reimbursement Methodology

Blue MA reimburses network providers at the reimbursement level stated in the provider's Medicare Advantage Agreement minus any member required cost sharing, for all medically necessary services covered by Original Medicare or an enhanced Blue MA benefit. BCBSKS will reimburse the RHC and FQHC encounter rate at the Medicare level.

Clean claims are processed and paid within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, interest will be paid in accordance with CMS regulations.

Claims are processed in accordance with Original Medicare guidelines. Providers must bill Blue MA in the same manner they bill Original Medicare (i.e, if an RHC or FQHC with Original Medicare, you must file Blue MA Claims as an RHC or FQHC). Blue MA will not reimburse providers for services that are not covered under Original Medicare, unless such services are specifically listed as covered services under the member's particular Blue MA health benefit plan.

Blue MA must also comply with all applicable CMS Original Medicare manuals, instructions, directives and guidance, including Medicare national coverage determinations, general coverage guidelines, and written coverage decisions of the local Medicare Administrative Contractor.

Providers should follow all applicable Original Medicare guidelines and include the following on all claims:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, you must supply all applicable digits.
- Services coded with Not Otherwise Classified (NOC) codes, without an associated fee, will be priced at 65 percent of charge.
- National coding guidelines.
- Medicare Part B supplier number, national provider identifier and federal tax identification number.
- The member's Blue MA number, including the **M3A** alpha prefix, found on the member's ID card.

Critical Access Hospitals and Rural Health Clinics

Reimbursement for inpatient and outpatient services will be based on the critical access hospital's or rural health clinic's most recent interim rate letter from their A/B Medicare Administrative Contractors. To ensure appropriate reimbursement, a copy of the current interim rate letter is necessary to be provided at initial contracting and each following year when CMS provides updated interim rate letters. These letters must be provided timely, so the system is set to pay according to the letter. Email the rate letters to marateletters@bcbsks.com.

To ensure proper reimbursement throughout the year, hospitals must retrieve their current year rates from the Fiscal Intermediary/MAC and submit the rate letter (or system equivalent) to BCBSKS.

BCBSKS will conduct cost settlements for critical access hospitals (CAH) and qualifying rural health clinics (RHC) for BCBSKS Preferred Blue Medicare advantage members (members with card prefix M3A). During the first year only, the provider may choose to accept or forego the settlement process. This determination will apply as long as the contracting agreement remains in effect.

BCBSKS will review the Medicare cost report and the BCBSKS Medicare Advantage claims. Settlements will be based on the Medicare cost report for service dates within the cost reporting period.

If the settlement option is chosen, the provider must submit to BCBSKS the filed Medicare Cost Report and the letter acknowledging the outcome of the settlement from Medicare. BCBSKS will review the information and will provide written determination of funds owed to the provider from BCBSKS or funds owed BCBSKS from the provider. Payment of the settlement will be due by either party 60 days after final terms of the BCBSKS Medicare Advantage settlement are completed.

Member Financial Obligations

In most situations, Blue MA members will be responsible for part of a provider's bill for services; and, as the provider agreement with Blue MA outlines, providers will not waive these member financial responsibilities, (i.e. the member co-payment, coinsurance and deductible) as specified in the member's health plan or contract.

Non-covered services

Members will generally be exclusively responsible for any non-covered services provided. As specified in the provider agreement, providers may not bill members for services that do not meet Medicare Coverage Criteria (e.g., experimental/investigational), unless a waiver is first obtained. The Advanced Beneficiary Notice of Non-Coverage waiver is available at bcbsks.com for the provider notice and member agreement information regarding billing for non-covered services.

Please note that except for applicable co-payment, co-insurance or deductible, providers are not permitted to request or require payment in advance by any of Blue MA members or from anyone else as a condition of providing services to members.

Billing

Providers are not permitted to "balance bill" a member for amounts in excess of the Medicare allowance (member co-payment, co-insurance and deductible are considered part of the allowance for this purpose, and should be billed to the member) for covered services, in accordance with the conditions of the contracting provider agreement, CMS regulations, and 42 CFR § 422.214 for providers not participating in the Kansas Preferred Blue Medicare Advantage network. Providers are also responsible for any billing or collection service activities that they may engage, or to whom a provider may assign any accounts receivable or other claims against Blue MA members.

If Blue MA finds that a provider, billing service, collection agency, or other agent engaged by a provider has improperly attempted to bill any member or collect any amounts from members in violation of the provider agreement or the guidelines in this manual, providers are obligated to promptly take all necessary steps to halt any such activity, to ensure that it is not repeated, and to reimburse Blue MA and the member for any expenses or losses incurred in responding to or defending against the claims or collection actions of any such billing service, collection agency or other agent. Providers may also be excluded from the network for failure to adhere to the member "hold harmless" agreement.

Dual Eligible

CMS prohibits billing members in the Qualified Medicare Beneficiary (QMB) program. The QMB program serves members enrolled in Original Medicare or a Medicare Advantage plan with a supplemental State Medicaid plan covering Medicare deductibles, coinsurance and co-payments under certain circumstances. Federal Law prohibits Medicare Advantage (MA) providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or co-payments from those enrolled in the QMB program. MLN Matters: SE1128

Co-pays

CMS Medicare Managed Care manual provides guidance on acceptable cost-sharing. The following indicates benefits and beneficiary protections:

The 50 percent cap on Original Medicare services: In order for an Original Medicare in-network or out-of-network item or service category to be considered a plan benefit, plans may not pay less than 50 percent of the contracted (or Medicare allowable) rate and cost-sharing for services cannot exceed 50 percent of the total MA plan financial liability for the benefit.

Consequently:

- If a plan uses a co-insurance method of cost-sharing, then the co-insurance for an in-network or out-of-network service category cannot exceed 50 percent.
- If a plan uses a co-pay method of cost-sharing, then the co-pay for an out-of-network Original Medicare service category cannot exceed 50 percent of the average Medicare rate in that area.
- If a plan uses a copay method of cost-sharing, then the copay for an in-network original Medicare service category cannot exceed 50% of the average contracted rate of that service.
- The 50% cap is in addition to any other caps. Thus, for those service categories subject to fee-for-service cost-sharing limits (e.g. 20% coinsurance) the plan may not charge more than the fee-for-service cost-sharing limit.

Refunds

While all parties strive for accurate claim adjudication on the first pass, occasionally adjudication mistakes are detected that result in the need to adjust the amount paid. When the adjustment results in a reduction of the claim payment amount, Blue MA sends the provider notice of any overpayments through a refund request letter as well as on the Explanation of Payment (EOP) in the section called “Adjustments”. The notice contains patient and claim information including the patient account number for ease of tracking.

Blue MA prefers providers allow recovery of the overpayment from a future remittance if the provider agrees with the overpayment determination. This requires less administrative work for the provider and Blue MA.

In order to ‘close’ patient accounts more timely, Blue MA will initiate the recovery through the RA within approximately 10 days following notice on the EOP or letter to the provider, assuming the provider has claims payments to cover any, or all, of the overpaid amount. If the

provider does not have claim payments sufficient to cover the overpayment during a 90-day period, Blue MA will send a follow-up requesting a check for the overpaid amount.

Please note that if Blue MA must offset to recoup duplicate or erroneous payments (overpayments) made to providers, providers are not allowed to pursue collection of such offset amounts from the members against whose claims such offsets are made.

Explanation of Payment

An EOP will accompany the reimbursement from Blue MA for services rendered to members. The check must be cashed or deposited with in six months of the check date to be valid. The standard EOP provides line-by-line detail. If a provider uses a billing service, please send copies of the EOP to the billing company. Most of the column headings on the EOP are self-explanatory.

EOPs will not typically be mailed if a provider is paid by Electronic Funds Transfer (EFT). EOPs are available by mail, or through Electronic Remittance Advice (ERA) ANSI x12 835 transaction. Providers who are signed up to receive Electronic Remittance Advices/835s for commercial business, are automatically enrolled for Medicare Advantage electronic remittance advices. MA 835s are delivered weekly, typically on Thursdays. Please ensure that your clearinghouse/vendor is looking for these files, so they are picked up and delivered appropriately. The files are placed in the same location as BCBSKS remits, and the filename begins with “ADV835”. At this time, we continue to work to make Blue MA EOPs available online by logging into Availity, in the Blue Medicare Advantage provider secure section

Example of EOP

EXPLANATION OF PAYMENTS

BlueCross Blue Shield of Kansas
Address Line 1
Address Line 2
City, State Zip

Tax ID: 123456789
Check Number: 40000017
Check Amount: $7.24
Check Date: 01/01/2019
NPI: 1234567890

Provider Name
Address Line 1
Address Line 2
City, State Zip

Patient Name:	First M Last	Provider/Prof:	Prov Name
Insured No:	12345678900	Provider/Prof No:	1234567
Patient No:	12345678900	Employer Name:	Name
Pat Acct No:	999999999	Employer ID:	999999999

Network: Network

Claim No: 1234567890

Service Dates	Service Code	Quantity	Charged Amount	Allowed Amount	Discount	Coinsurance	Deductible	Copay	Sequestration	Withhold	Paid Amount
01/01/2017 - 01/01/2017	12345	1	$110.00	$3.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.62
EOP Codes: 123,456 Denial Code and Reason											
01/01/2017 - 01/01/2017	12345	1	$110.00	$3.62	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$3.62
EOP Codes: 123,456 Denial Code and Reason											
Totals this claim:			$220.00	$7.24	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$7.24
Interest paid this claim:											$0.00
Adjustment amount this claim:											$0.00
Total paid this claim:											$7.24
Paid by primary payer:											$0.00
Remark Code: 105											

Example EOP Notice of Offset

This is an offset of a previously processed claim

Patient Name:	First M Last	Provider/Prof:	Prov name
Insured No:	12345678900	Provider/Prof No:	1234567
Patient No:	12345678900	Employer Name:	Name
Pat Acct No:	999999999	Employer ID:	999999999

Network: Network

Claim No: 1234567890

Claim ID	First Service Date	Paid Amount	Interest	Adjustment Amount	Sub Total	Received Refund	Total	Refund	Check Adjustment
1234567890	01/01/2017	$100.00	$0.01	$0.00	$100.01	$100.01	$0.00	$0.00	-$100.01

Explanation of Check Adjustments

Claim ID	Patient Account Number	Paid Amount	Interest	Adjustment Amount	Sub Total	Received Refund	Total	Refund	Check Adjustment
1234567890	12345678900	$100.00	$0.01	$0.00	$100.01	$100.01	$0.00	$0.00	-$100.01
Totals		$100.00	$0.01	$0.00	$100.01	$100.01	$0.00	$0.00	-$100.01
Adjustment Reason: 12345678900 38 Miscellaneous									

EOP Explanation

123	Explanation Text
456	Explanation Text
789	Explanation Text
111	Explanation Text

Page No: 3 Prov Name

Chapter 5: Coverage Policy

Blue MA follows the coverage policy for Medicare. The Medical Policy Hierarchy is available at bcbsks.com.

Policies and Procedures, Medical Management Resources, and forms such as the Advanced Beneficiary Notice of Non-Coverage, Prior Authorization Assessments, and Satisfaction Surveys can be found https://www.bcbsks.com/providers/medicare-advantage.

Chapter 6: Medical Records Requirements and Requests
Medical Records

Patient medical records and health information shall be maintained in accordance with current federal and state regulations (including prior consent when releasing any information contained in the medical record).

Blue MA providers must maintain timely and accurate medical, financial and administrative records related to services they render Blue MA members, unless a longer time period is required by applicable statutes or regulations. The provider shall maintain such records and any related contracts for 10 years from date of service.

The provider shall give without limitation, Blue MA, U.S. Department of Health and Human Services, U.S. General Accounting Office, or their designees, the right to audit, evaluate, and inspect all books, contracts, medical records, and patient care documentation, maintained by the provider, which will be consistent with all federal, state and local laws. Such records will be used by CMS and Blue MA to assess compliance with standards which includes, but not limited to:

1. Complaints from members and/or providers;
2. HEDIS, STARs and other reviews, quality studies/audits or medical record review audits;
3. CMS and Blue MA reviews of risk adjustment data;
4. Post-pay reviews to determine whether services are reasonable and medically necessary and billed correctly to the plan.
5. Pre-service organization determinations, redeterminations and appeals decisions;
6. Medical, Disease and Utilization Management specific medical record reviews;
7. Suspicion of fraud, waste and/or abuse;
8. Periodic office visits for contracting purposes; and other reviews contracting appropriate and/or necessary.

Medical record content and requirements for all providers (for behavioral health providers see paragraph below) include, but may not be limited to:

Clinical record

Patient name, identification number (name and ID number must be on each page), address, date of birth or age, sex, marital status, home and work telephone numbers, emergency contact telephone number, guardianship information (if relevant), signed informed consent for

immunization or invasive procedures, documentation of discussion regarding advance directives (18 and older) and a copy of the advance directives.

Medical documentation

- History and physical, allergies, adverse reactions, problem list, medications, documentation of clinical findings evaluation for each visit, preventive services and other risk screening.
- Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
- Past medical, surgical and behavioral history, if applicable, chronic conditions, family history, medications, allergies, immunizations, social history, baseline physical assessment, age and sex specific risk screening exam, relevant review of systems including depression and alcohol screening.
- Documentation of patient education (age and condition specific), if applicable: injury prevention, appropriate dietary instructions, lifestyle factors and self-exams.

Clinical record – progress notes

- Identification of all providers participating in the member's care and information on services furnished by these providers.
- Reason for visit or chief complaint, documentation of clinical findings and evaluation for each visit, diagnosis, treatment/diagnostic tests/referrals, specific follow-up plans, follow-up plans from previous visits have been addressed and follow-up report to referring provider (if applicable).

Clinical record – reports content

(all reviewed, signed and dated within 30 days of service or event)

Lab, X-ray, referrals, consultations, discharge summaries, consultations and summary reports from health care delivery organizations, such as skilled nursing facilities, home health care, free-standing surgical centers, and urgent care centers.

Behavioral health providers

- Chief complaint, review of systems and complete history of present illness
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history

- Past medical history
- A medication list including dosages of each prescription, the dates of the initial prescription and refills
- At least one complete mental status examination, usually done at the time of initial evaluation and containing each of the items below:
  - Description of speech
  - Description of thought processes
  - Description of associations (such as loose, tangential, circumstantial, or intact)
  - Description of abnormal or psychotic thoughts
  - Description of the patient's judgment
- Complete mental status examination
- Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content (including any thoughts of harm), mood, affect and other information relevant to the case.
- A DSM-IV diagnosis, consistent with the presenting problems, history, mental status examination and other assessment data
- Thorough assessment of risk of harm to self or others
- Informed consent indicating the member's acceptance of the treatment goals. Formal signed consent is not required except where required by law.
- To ensure coordination of the member's care, the treatment records shall reflect continuity and coordination of care with the member's primary care provider and as applicable; consultants, ancillary providers and health care institutions involved in the member's care.
  - Where it is required by law, proper documented written and signed consent for any release of information to outside entities has been obtained.
  - Progress notes shall describe the member's strengths and limitations in achieving the treatment goals and objectives.
  - Evidence that members who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

Other medical record requirements

The provider of service for all face-to-face encounters must be identified on the medical record, which includes: signature and credentials (can be located anywhere on record, including stationery) for each date of service. Stamped signatures are not acceptable.

Electronic signature on electronic health records (EHR) are acceptable if authenticated at the end of each note in accordance with CMS authentication requirements. Additionally, electronic signatures must contain the following key elements: the practitioner's name, credentials, date and a printed attestation statement (e.g. "accepted by," "acknowledged by," "approved by," "authenticated by," "closed by," "digitally signed by," "electronically authored by," "finalized by," "generated by," "released by," reviewed by," "signed by," "validated by," etc.)

Handwritten signatures may only be used on handwritten, transcribed or dictated reports. Handwritten signatures are NOT valid on reports generated from an EHR system. The CMS Medicare Program Integrity Manual (Ch.3) states that a provider's handwritten signature is acceptable if it is:

- A fully legible signature, including credential.
- A legible first initial, last name and credential when letterhead, addressograph or other information on the page indicates the identity of the signer.
- An illegible signature, or initials when over a typed or printed name and credential.
- An illegible signature when the letterhead, addressograph or other information on the page indicates the identity and credential of the signer.

It's very important for provider signatures to meet this criterion. As stated by the CMS Medicare Program Integrity Manual, "Medicare requires that services provided/ordered be authenticated by the author." This means that without a proper signature on the medical record entry, the record can be deemed invalid, thus hindering patient care. If using an EHR, you can consult with technical staff and software vendors to ensure the integrity of your documentation and signatures.

For further guidance please refer to the Medicare Program Integrity Manual at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf.

Confidentiality of Member Information

In accordance with the highest standards of professionalism, and as a requirement of each provider's contract with Blue MA, providers are obligated to protect the personal health information of Blue MA members from unauthorized or inappropriate use. All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements.

Routine Needs for Member Information

At the time of enrollment, members who enroll electronically or by paper, permit Blue MA to use and disclose their personal health information for routine needs such as:

- Bona fide research purposes
- Claims processing (payment, denial, investigation)
- Coordination of care
- Customer service
- Data processing
- Fraud/Abuse investigations or reports
- Health care operations
- Medical management
- Performance measurement
- Provider credentialing or quality evaluation
- Quality assessment and measurement
- Regulatory audits or inquiries, subpoenas, or other court or law enforcement procedures
- Required regulatory reports
- Risk Adjustment and HEDIS
- Routine audits
- Utilization review

If Information Is Needed for Other Reasons

If member-specific and identifiable information is needed for reasons other than those listed above under “routine needs,” the member must sign specific authorization to release the information. If a member is unable to give prior authorization personally, Blue MA has a process to obtain this consent through a parent's or legal guardian's signature, signature by next of kin, or attorney-in-fact. While specific authorizations are issued, the member has the right to limit the purposes for which the information can be used, and all concerned are obligated to respect that expressed limitation.

Members Rights to Medical Records

Members have the right to access their medical records. Therefore, each provider must have a mechanism in place to provide this access. Members must not be interviewed about medical, financial or other private matters within the hearing range of other patients. Providers must have procedures in place for informed consent, storage and protection of medical records. Blue MA may verify that these policies/procedures are in place as part of an on-site review process.

Blue MA Employees

As a condition of employment, all Blue MA employees must sign a statement agreeing to hold member information in strict confidence. Providers and all other Blue MA participating providers also are bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information.

Chapter 7: Network Terms and Conditions
Network Participation Guidelines

Providers requesting participation in the KPBMA network must agree to follow CMS, the policies and procedures, terms and conditions, and meet applicable credentialing standards. Network participation includes all eligible services provided by the legal business entity identified on the contract. The legal business entity is identified by the entities tax identification number which may have multiple billing NPIs.

Providers who have questions about participation should contact their Professional Relations representative or Institutional Provider Consultant.

Section 1: Introduction

Blue MA allows members to use any provider, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Original Medicare or eligible to be paid by Blue MA for benefits that are not covered under Original Medicare.

If you have an opportunity to review these terms and conditions of payment and you treat a Blue MA member, you will be “contracting” with Blue MA. Section 2 explains how the contracting process works. The rest of this document contains the contract between you, the provider, and Blue MA. Any provider in the United States that meets the criteria in Section 2 is contracting with Blue MA for the services furnished to the member when the contracting conditions are met.

No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member. However, a member or provider may request an Organization Determination before a service is provided in order to confirm the service is medically necessary and will be covered by the plan. Section 7 describes how a provider can request an Organization Determination.

Providers that have signed the Blue MA agreement are considered in-network providers. Members can still receive services from non-network providers who do not have a signed contract with us, as long as the provider meets the contracting criteria described in Section 2. These contracting providers are subject to all of the terms and conditions of payment described in this document.

To access the list of providers who participate with Blue MA, go to https://www.bcbsks.com/medicare/find-a-provider.shtml. The amount of cost-sharing a member pays an out-of-network provider may be more than the cost-sharing the member pays an in-network provider. Services the cost-sharing amount differs between in- and out-of-network providers are indicated in the Blue MA member Evidence of Coverage (EOC).

Section 2: When a provider is contracted to accept the Blue MA terms and conditions

A provider is considered contracted with Blue MA when all of the following three criteria are met:

- The provider is aware in advance of furnishing health care services that the patient is a member of Blue MA. All Blue MA members receive an ID card that includes the logo, which clearly identifies them as members. The provider may validate eligibility by logging into Availity.com and selecting Blue MA from the resource tab on the BCBSKS payor space, or calling Blue MA Provider Services at 800-240-0577.
- The provider either has a copy of, or has reasonable access to, the Blue MA terms and conditions of payment (this document).
- The provider furnishes covered services to a Blue MA member.

If all of these conditions are met, the provider is considered contracting and has agreed to the Blue MA terms and conditions of payment for that member specific to that visit. For example, if a patient shows an enrollment card identifying him or her as a Blue MA member and you provide services to that member, you will be considered a contracting provider. Therefore, it is the provider's responsibility to obtain and review the terms and conditions of payment before providing services, except in the case of emergency services (see below).

Note – Non-contracting providers can decide whether or not to accept the Blue MA terms and conditions of payment each time you see a Blue MA member. A decision to treat one plan member does not obligate you to treat other Blue MA members nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you DO NOT wish to accept the Blue MA terms and conditions of payment, then you should not furnish services to a Blue MA member except for emergency services. If you do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contracting providers and paid at the Original Medicare rate.

Section 3: Provider qualifications and requirements

In order to be paid by Blue MA for services provided to a member, you must:

- Have a National Provider Identifier (NPI) in order to submit electronic transactions to Blue MA, in accordance with HIPAA requirements.
- Submit all claims (electronic or paper) to your local Blue plan.
- Furnish services to Blue MA members within the scope of your licensure or certification.
- Provide only services that are covered by Blue MA and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted-out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider list.
- Not be a federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with Blue MA to resolve any member grievance involving the provider within the time frame required under federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements).
- Not charge the member in excess of cost-sharing allowed under these terms and conditions under any condition, including in the event of bankruptcy.

Section 4: Payment to Providers

- Blue MA reimburses contracting providers by the rate specified in the contract minus any member required cost-sharing for all medically necessary services covered by Medicare.
- Blue MA will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then Blue MA will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules.
- Contracting providers furnishing services to Blue MA members must accept the specified amount in the contract minus applicable member cost-sharing as payment in full.

Member benefits and cost-sharing

Payment of cost-sharing amounts is the responsibility of the member. Providers should collect the applicable cost-sharing from the member at the time of the service when possible. Providers can only collect from the member the appropriate Blue MA co-payments or coinsurance amounts described in these terms and conditions. After collecting cost-sharing from the member, providers should bill Blue MA for covered services. Section 5 provides instructions on how to submit claims. **Note** – Blue MA may not hold members accountable for any cost-sharing (deductibles, co-payments, coinsurance) for Medicare-covered preventive services that are subject to zero cost-sharing.

If a member is a dual-eligible Medicare beneficiary (a member enrolled in Blue MA and a State Medicaid program), the provider cannot collect any cost-sharing for Original Medicare services from the member at the time of service when the State is responsible for paying such amounts (nominal co-payments authorized under the Medicaid State plan may be collected). Instead, the provider may only accept the Blue MA payment (plus any Medicaid co-payment amounts) as payment in full or bill the appropriate State source.

To view a complete list of covered services and member cost-sharing amounts under Blue MA, go to https://www.bcbsks.com/CustomerService/Providers/medicare-advantage/. You can log onto Availity.com or call 800-240-0577 to obtain more information about covered benefits, plan payment rates, and member cost-sharing amounts under Blue MA. Be sure to have the member's ID number including the three-character alpha prefix.

Blue MA follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Blue MA, unless specified by the plan. Information on obtaining a Coverage Determination can be found in Section 7. Blue MA does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage.

Note – Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost-sharing amounts for MA plans. All cost-sharing is the member's responsibility.

Hold-harmless requirements

In no event, including but not limited to non-payment by Blue MA, insolvency of Blue MA, and/or breach of these terms and conditions, shall a contracting provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse

against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, a refund of that amount must be made to the member.

Section 5: Filing a claim

- You must submit a claim to Blue MA for an Original Medicare-covered service within the same time frame you would have to submit under Original Medicare, which is within 365 days after the date of service. Failure to be timely with claim submissions may result in non-payment. The rules for submitting timely claims under Original Medicare can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/837P-CMS-1500.pdf.
- Prompt Payment—Blue MA will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Blue MA will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Blue MA will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims. The following are excluded from Prompt Pay Interest:
    - Medicare supplement claims
    - FEP
    - Claims for ASO and Modified ASO groups
    - Network Pricing
    - Long term care
    - Adjustments (except for same cycle adjustments and adjustments to OPL remarks 77, 85, 87, or D1)
    - ITS Host claims except for claims for KC Plan insureds and the patient’s residential location is in KS
    - PIP Payments
    - Medicaid payments
    - Claims being investigated for fraud
    - Capitated services
    - History Loads

- Submit claims using the standard CMS-1500, UB-04, or the appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes, and defined modifiers. Bill diagnosis codes to the highest level of specificity. Some exceptions may apply, please visit our Medicare Advantage Provider web page, https://www.bcbsks.com/providers/medicare-advantage, to see specific billing guidelines that do not follow Medicare's guidelines.
- Include National Provider Identifier (NPI), the member's ID including three-digit prefix, and the date(s) of service.
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.
- Coordination of Benefits: All Medicare secondary payor rules apply. These rules can be found in the Medicare Secondary Payor Manual located at: http://www.cms.gov/Manuals/IOM/list.asp. Providers should identify primary coverage and provide information to Blue MA at the time of billing.
- Submit both electronic and paper claims to your local Blue Plan.
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 800-240-0577.

Section 6: Maintaining medical records and allowing audits

Contracting providers shall maintain timely and accurate medical, financial, and administrative records related to services rendered to Blue MA members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service.

Contracting providers must provide Blue MA, the Department of Health and Human Services, the Comptroller General, or their designees' access to any books, contracts, medical records, patient-care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in an MA plan, consistent with federal and state privacy laws. Such records will primarily be used for CMS audits of risk adjustment data upon which CMS capitation payments to Blue MA are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

Blue MA also may request records for activities in the following situations: Blue MA audits of

risk adjustment data, determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make Coverage Determinations.

Blue MA will not use these records for any purpose other than the intended use. Providers are required to furnish these member medical records without charge.

Blue MA will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

Section 7: Getting a pre-service Coverage/Organization Determination

Providers may choose to obtain a written pre-service Organization Determination (Medical/Part C) or Coverage Determination (Pharmacy/Part D) from Blue MA before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Blue MA. To obtain a pre-service Determination, call Blue MA Provider Services at 800-240-0577 or fax to 800-976-2794. Blue MA will notify the provider and member of the decision within 14 days for an Organization Determination and 72 hours for a Coverage

Determination, with a possible 14-day extension either because of the member's request or Blue MA justification that the delay is in the member's best interest. In cases where the provider believes waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, an Expedited Determination can be requested.

To request an Expedited Determination, call Blue MA Provider Services at 800-240-0577 and state you are requesting an Expedited Determination. Blue MA will notify you of the decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours for an Organization Determination or 24 hours for a Coverage Determination after receiving the request, unless the 14-day extension is invoked either based on the member's request or Blue MA's justification (for example, the receipt of additional medical evidence may change Blue MA's decision to deny) the delay is in the member's best interest. In the absence of a pre-service Determination, Blue MA may retroactively deny payment for a service furnished to a member if the service is determined not covered or was not medically necessary. All providers have the right to dispute the decision by exercising member appeals rights (see pages 76-80 or the Federal regulations at 42 CFR Part 422, subpart M, or Chapter 13 of the Medicare Managed Care Manual).

Section 8: Provider Appeals/Payment Dispute resolution process

If you believe that the payment amount you received for a service is less than the amount indicated in the Blue MA terms and conditions of payment, you have the right to dispute the payment amount by following the Blue MA Appeals and Payment Dispute process, which is outlined in chapter 15 of this manual.

Note that in cases where Blue MA re-adjudicates a claim, the provider has an additional 120 days from the date you are notified of the re-adjudication in which to dispute the re-adjudicated claim.

If Blue MA agrees with the reason for your payment dispute, Blue MA will pay you the additional amount you are requesting, including any interest that is due. Blue MA will inform you in writing if the decision is unfavorable and no additional amount is owed.

Section 9: Member and provider appeals and grievances

Members have the right to file appeals and grievances with Blue MA when concerns or problems arise related to coverage or care. Members may appeal a decision made by Blue MA to deny coverage or payment for a service or benefit they believe should be covered. Members should file a grievance for all other types of complaints not related to the provision or payment for health care.

A provider who is providing treatment may, upon notifying the member, appeal pre-service Determination denials to the plan on behalf of the member. The provider may also appeal a post-service Determination denials as a representative, or sign a Waiver of Liability (promising to hold the member harmless regardless of the outcome) and appeal the denial using the appeal process. There must be potential member liability (e.g., an actual claim for services already rendered as opposed to a pre-service Organization/Coverage Determination) in order for a provider to appeal utilizing the member-appeal process.

A non-contracting provider may appeal Organization/Coverage Determinations on behalf of the member as a representative, or sign a Waiver of Liability (promising to hold the member harmless regardless of the outcome) and appeal post-service Organization Determinations (e.g., claims) using the member-appeal process. As noted above, there must be potential member liability in order for a provider to appeal utilizing the member-appeal process.

If a provider appeals using the member-appeal process, the provider agrees to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PPO Member

appeals and grievance processes. See Chapter 15: Appeals and Payment Disputes for a complete outline of the Appeals process.

The Blue MA Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is posted under the Blue MA Member Forms section on our website, located at https://www.bcbsks.com/medicare/forms.

You can call Provider Services at 800-240-0577 for more information on our member appeals and grievance policies and procedures.

Section 10: Providing members with notice of their appeal rights – Requirements for Hospitals, SNFs, CORFs and HHAs

Hospitals must notify all Medicare beneficiaries – including Blue MA members – who are hospital inpatients about discharge appeal rights by complying with the requirements for providing the Important Message from Medicare About Your Rights form, including complying with the normal time frames for delivery. For copies of the notice and additional information regarding this requirement, go to: http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries – including Blue MA members – about their right to appeal a termination of services decision by complying with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC), including complying with the normal time frames for delivery. For copies of the notice and the notice instructions, go to: http://www.cms.gov/BNI/09_MAEDNotices.asp.

As directed in the instructions, the NOMNC should contain Blue MA contact information somewhere on the form (such as in the additional information section on page 2 of the NOMNC).

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities, and skilled nursing facilities must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-Coverage) within the time frames specified by law. For copies of the notices and the notice instructions, go to: http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp and http://www.cms.gov/BNI/09_MAEDNotices.asp.

Section 11: Additional Information

If you have general questions about Blue MA terms and conditions of payment, contact us at 800-240-0577, 8 a.m. to 6 p.m. Monday through Friday. If you have questions about submitting claims, call 800-240-0577.

Chapter 8: Pharmacy

Pharmacy Directory

Providers may search for a KPBMA network pharmacy by using the online directory at https://www.bcbsks.com/documents/2023-pharmacy-directory-ma-ma-comp-and-ma-choice-37-028-2022-12-01.

Pharmacy Formulary

Providers may access the Medicare Advantage Formulary by using the online search tool at https://www.bcbsks.com/medicare/find-a-prescription.

Blue MA Part D Prescriber Requirements

CMS has made changes for any provider or other eligible provider who prescribe Medicare Advantage (Part D) covered drugs. Providers must either enroll in the Original Medicare program or "opt out" in order to prescribe covered medications to patients who have a Part D prescription drug benefit plan. Providers who are not enrolled should do so as soon as possible to allow for the processing of applications and to ensure enrollees will continue to receive their Part D covered prescriptions.

Note – Part D benefit plans will not be allowed to cover drugs that are prescribed by providers who have not enrolled with or have not opted out of the Medicare program.

To comply with the CMS change, Blue MA will require all providers to be enrolled in Original Medicare before they can be considered for participation in the KPBMA network.

Utilization Management

Certain drugs must undergo a criteria-based approval process before a coverage decision. Blue MA's pharmacy and therapeutics committee reviews medications based on safety, efficacy, and clinical benefit, and may make additions or deletions to the list of drugs requiring prior authorization and to the list of drugs that have quantity limits. Prior authorizations for drugs will be implemented in 2021.

Please call (866) 230-7265 with questions related to coverage for a specific drug.

Excluded Medications

Blue MA does not cover all prescription drugs. Here are three general rules about drugs that Medicare drug plans will not cover under Part D.

1. Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.

2. Blue MA cannot cover a drug purchased outside the United States and its territories.
3. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration. Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, the plan cannot cover its “off-label use.”

Also, by law these categories of drugs are not covered by Medicare drug plans.

- Non-prescription drugs
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Additional information about prescription drug coverage can be obtained by calling 800-240-0577.

Chapter 9: Provider Information

Information Changes/Updates

CMS requires providers to attest to the accuracy of directory data on a quarterly basis with the health plan. Providers who are contracted as a Blue MA provider are required to attest to their information through the Availity portal. When attesting quarterly, providers will be satisfying both the CMS requirement and the Blue MA bi-annual requirement.

Requests to term from Blue MA

The CMS Medicare Advantage application timeline requires plans to attest and submit data for network adequacy in June of each year for the preceding year. The request to term network status with Blue MA must be received in writing by April 1 for the preceding year. This CMS time frame does not follow the same time frame as the annual Blue MA CAP renewal process.

Provider Communication

Communication is an important factor in delivering quality services to members and educating providers. In an effort to communicate any updates, improvements in policies and procedures, topics of interests, and other pertinent information, Blue MA will make available on the bcbsks.com MA website resources to assists providers and send an email notice when new information is available. Like Original Medicare, the Blue MA communications will be conducted electronically.

Fraud, Waste, and Abuse

Fraud is the intentional misrepresentation that an individual makes that could result in some sort of unauthorized benefit to himself or herself, or to another person. The most frequent kind of fraud arises from a false statement or misrepresentation made in regard to entitlement or payment under Medicare. Abuse includes actions that may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Anti-Fraud, Waste, and Abuse Policy Statement

As an integral part of the compliance plan, Blue MA supports and maintains provisions for the prevention, detection, and correction of fraud, waste, and abuse related to all benefits of the plan, including Medicare operations. Under the direction of the Board, CEO, compliance officer and compliance committees, comprehensive written policies, procedures, and standards of conduct are implemented to comply with all applicable federal and state standards.

Annual Compliance Training for Providers

As a contractor for CMS, Blue MA is required by the Medicare Managed Care Manual (42CFR Parts 422 and 423) Chapter 21: Compliance Program Guidelines, and Chapter 9: Prescription Drug Manual to communicate information, including annual compliance training information to all first-tier, downstream, and related entities (FDRs). As a contracted provider (FDR) that provides a service to our Blue MA and Medicare Part D members, you are required to complete annual Medicare compliance training. It also is the provider's responsibility to ensure that all staff serving these Medicare Beneficiaries completes the annual compliance training. This includes front office, lab techs, nurses, billing and any other ancillary staff. Compliance training should be completed annually no later than Dec. 31 or within 90 days of hire for any new employees. The OIG has issued guidance with reference to "effective compliance programs" for specific health care providers that can be found at http://oig.hhs.gov/compliance/101/index.asp.

To ensure this requirement is met and to largely reduce the duplicative training required of FDRs by multiple organizations, CMS developed web-based compliance training. FDRs have two options for ensuring its FDRs (including the FDR's employees) have satisfied the general compliance and Fraud, Waste, and Abuse training requirement as described in the regulations and sub-regulatory guidelines.

1. FDRs /DEs and their employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN). Once an individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be retained by all FDRs/DEs for 10 years. This training is also available as a pdf at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.html.
2. FDRs/DEs may download, view, or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization's existing compliance

training materials/systems. In order to ensure the integrity and completeness of the training, CMS training content cannot be modified. However, an organization can add to the CMS training to cover topics specific to their organization.

Training materials are available on CMS's MLN Network at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html under Downloads, Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training. All training documents, including a copy of the training materials and training logs, must be retained by your organization for 10 years, in accordance with CMS record retention guidelines. All documentation is subject to random audit by Blue MA or may be requested as part of a Compliance Program Audit by CMS or CMS designees.

In addition to online training, a pdf of CMS's Medicare C and D Compliance Training for Providers is available on the website at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf.

Chapter 10: HEDIS & Stars
Quality Improvement Program

Blue MA is committed to improving the quality of health care for members. Blue MA maintains a quality improvement program that continuously reviews and identifies the quality of clinical care and services members receive and routinely measure the results to ensure members are satisfied and expectations are met.

The Blue MA Quality Improvement (QI) unit develops an annual quality improvement program that includes specific quality improvement initiatives and measurable objectives. Activities that are monitored for QI opportunities include:

- Appointment and after-hours access monitoring
- Quality of care concerns
- Member satisfaction
- Chronic care management
- Utilization management
- Health outcomes
- Medical record documentation compliance
- Quality improvement projects
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS) and Health Outcomes Survey (HOS)
- Regulatory compliance

Healthcare Effectiveness Data and Information Set (HEDIS)

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. Blue MA follows HEDIS reporting requirements established by the National Committee for Quality Assurance (NCQA) and CMS. Audited HEDIS reports are used to identify quality improvement opportunities and develop quality related initiatives.

The HEDIS measures Blue MA focuses on, may include (but are not limited to):

- Acute hospital utilization
- Adults access to preventive/ambulatory health services
- Breast cancer screening (women 50–74 years of age)
- Colorectal cancer screening (members 50–75 years of age)
- Comprehensive diabetes care
    - Blood pressure control <140/90
    - Dilated retinal eye examination
    - HbA1c testing, poor and good control
- Controlling high blood pressure
- Fall risk management
- Flu vaccinations for adults age 65 and older
- Follow-up after emergency department visit for alcohol and other drug dependence (within seven and 30 days)
- Follow-up after emergency department visit for mental illness (within seven and 30 days)
- Follow-up after emergency department visit for people with high risk chronic conditions (within seven and 30 days)
- Follow-up after hospitalization for mental illness (within seven and 30 days)
- High risk medications
- Improving bladder control
- Inpatient utilization – general hospital/acute care
- Kidney health evaluation for patients with diabetes
- Medication adherence for diabetes medications
- Medication reconciliation post-discharge
- Medication therapy management
- Monitoring physical activity
- Opiod overutilization
- Osteoporosis management in women who had a fracture (women age 67–85)
- Plan all-cause re-admissions
- Statin therapy for patients with cardiovascular disease
- Statin therapy for patients with diabetes
- Transitions of care

CMS Quality Star Ratings Program

CMS evaluates health insurance plans and issues Star ratings annually. The CMS plan rating uses quality measurements widely recognized within the health care and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services Blue MA offers. CMS compiles its overall score for quality of services based on measures such as:

- How Blue MA helps members stay healthy through preventive screenings, tests and vaccines and how often they receive preventive services to help them stay healthy
- How Blue MA helps members manage chronic conditions
- Scores of member satisfaction with Blue MA
- How often members filed a complaint against Blue MA
- How well Blue MA handles calls from members

In addition, because Blue MA offers prescription drug coverage, CMS also evaluates Blue MA's prescription drug plans for the quality of services covered such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

CMS Star Ratings

CMS developed a set of quality performance ratings for health plans that includes specific clinical, member perception, and operational measures. The quality performance ratings include approximately 40 measures in five domains of care. Each of the measures has a defined "weight" used in calculating the Star ratings. Percentile performance is converted to Star ratings, based on CMS specifications, as one through five Stars, where five Stars indicate higher performance. This rating system applies to all Medicare Advantage lines of business: health maintenance organizations, preferred provider organizations and prescription drug plans. In addition, the ratings are posted on the CMS consumer website medicare.gov to help beneficiaries choose an MA plan offered in their area.

How are Star ratings derived?

A health plan's rating is based on measures in five categories:

Data source	Description	# of Metrics
HEDIS Part C	Subset of broad HEDIS data set used to measure health plans' ability to drive compliance with preventive care guidelines and evidence-based medical treatment guidelines related to clinical measures.	10
HEDIS Part D	Subset of broad HEDIS data set used to measure health plans' ability to drive compliance with preventive care guidelines and evidence-based medical treatment guidelines related to pharmacy measures.	4
CAHPS	Survey of randomly selected members focusing on member perception of their ability to access quality medical care.	9
HOS	Survey of randomly selected members focusing on member perception of their ability to access quality medical care.	4
CMS	Administrative data collected by CMS related to health plan service capabilities and performance.	9
Independent review entity	Timeliness and fairness of decision associated with appeals.	4

The methodology used by CMS is subject to change and final guidelines are released each fall.

The Star rating was developed to:

- Help consumers choose plans on medicare.gov/.
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D.
- Penalize consistently poor performing health plans.
- Strengthen beneficiary protections.

What is the Star measurement timeline?

CMS uses the Star rating system to validate data results as a new method of reviewing operational systems and verifying validity of data. Blue MA is accountable for the care provided by providers, hospitals, and other providers to their enrollees. The measures included in the Star measurement timeline and demonstrate clinical, perception, operations, and the published CMS rating for the review period. The data is a tool for quality improvement of internal and external processes.

Benefits

In most instances, the value of improving performance is well worth the investment for the health plan, the members, and the provider community. and individual needs.

Member benefits	Provider benefits	Blue MA benefits
Ensure members receive quality care that leads to positive health outcomes.	Improve care quality and health outcomes.	Improve care quality and health outcomes.
Greater health plan focus on access to care.	Improved patient relations.	Improved provider relations.
Improved relations with doctors.	Improved health plan relations.	Improved member relations.
Increased levels of customer service.	Increased awareness of patient safety issues.	Process improvement.
Early detection of disease and health care that matches.	Greater focus on preventive medicine and early disease detection.	Key component in financing health care benefits for MA plan enrollees.
	Strong benefits to support chronic condition management.	
	Partner with MA providers to encourage patients to get preventive screenings and procedures, and provide support in achieving certain disease.	

Goals for the Five-Star Ratings System

Blue MA is strongly committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. Through the Medicare Advantage Five-Star Rating Goals, Blue MA works with providers and members to ensure members received appropriate and timely care, chronic conditions are well-managed, members are pleased with the level of service from their health plan and care providers, and health plans follow CMS operational and marketing requirements.

Blue MA uses mailings and personal and automated phone calls to remind members about needed care and to help maintain optimal health.

Blue MA partners with our providers by identifying Blue MA patients who need specific medical services so providers can contact those patients and schedule necessary services.

Provider tips for Improving Star Ratings and Quality Care

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Understand the metrics included in the CMS rating system, as some of them are part of Blue MA provider Performance Excellence Program (PEP) to which you may be eligible to participate.
- Review the gap in care files listing members with open gaps.
- Ensure documentation includes assessment of cognitive and functional status.
- Identify opportunities for you or your office to have an impact.

2023 CMS Quality Star Measures

Although CMS uses up to 40 quality measures to determine a health plan's overall rating, Blue MA is evaluating the HEDIS measures for Blue MA for communication in early 2023 with an implementation date of Jan. 1, 2023.

Helpful links

- Blue MA Understanding STAR Ratings Manual - https://www.bcbsks.com/documents/understanding-star-ratings-manual-2022
- CMS Star Ratings Program - https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata
- HOS - https://www.hosonline.org/
- CAHPS - https://ma-pdpcahps.org/
- HEDIS - https://www.ncqa.org/hedis/

Chapter 11: Care Management Services

The Blue MA Care Management program promotes cost-effective and medically appropriate care and services. Components include clinical review of selected services, case management, care coordination, and chronic condition management programs.

Examples of services provided by the care management team include:

- Conducts timely reviews of all requests according to the type of service.
- Case management activities.
- Chronic disease management.
- Coordination of health care services with chronic condition management programs.
- Coordination of care among medical care providers and between medical and behavioral health care providers.
- Member health care education.
- Discharge planning.
- Health risk assessments.
- Assuring compliance with accrediting and regulatory governing bodies and Blue MA Quality improvement initiatives.

In April 2015, CMS released a notification regarding a new CPT code for chronic care management (CCM). The CCM CPT code is payable under Part B and is a covered Part B service by every MA Plan.

Contacting Care Management

Providers can contact Care Management during normal business hours at the number below, unless directed to use another number in this chapter. Normal business hours are 8 a.m. to 6 p.m. Monday through Friday. The department is closed for lunch for phone calls only from 11 a.m. to noon daily and on all major holidays.

Care Management/Transition – 800-325-6201

After Hours – 800-331-0192

Chapter 12: Utilization Management

Monitoring Utilization

Blue MA uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure Blue MA members receive the medical services required for health promotion, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of HEDIS data.
- Results of member satisfaction surveys.
- Rate of inpatient admissions.
- Rate of emergency services.
- Review of alternative levels of care such as observation.

Affirmation Statement

Blue MA bases its utilization decisions about care and service solely on their appropriateness in relation to each member's specific medical condition. Blue MA review staff has no compensatory arrangements that encourage denial of coverage or service. Clinicians employed by Blue MA do not receive bonuses or incentives based on their review decisions. Blue MA bases all clinical review decisions on medical necessity by applying approved clinical criteria and ensures that the care provided is within the limits of the member's plan coverage.

Contacting Utilization Management

Providers can contact Care Management during normal business hours at the number below, unless directed to use another number in this chapter. Normal business hours are 8 a.m. to 6 p.m. Monday through Friday. The department is closed for lunch for phone calls only from 11 a.m. to noon daily and on all major holidays.

Utilization Management – 800-325-6201

After Hours – 800-331-0192

Chapter 13: Authorizations and Clinical Review

Blue MA clinical review process is established to do the following:

- Ensure uniformity in the provision of medical care.
- Ensure the medical appropriateness and cost effectiveness of certain services.
- Improve the overall quality of care Blue MA members receive.
- Lower the cost of coverage for Blue MA members.

Blue MA determines which services are subject to clinical review by analyzing the plan's utilization data and comparing it with the following:

- Internal goals.
- External benchmarks, such as HEDIS.

Other factors are also taken into consideration, such as:

- Procedures high in cost or volume.
- Trends toward increasing use of a procedure or service.
- Evidence of or reason to suspect actual or potential misuse.
- Variations in practice patterns.

In deciding which services require clinical review, Blue MA also looks carefully at:

- The negative impact the proposed review program might have on providers.
- The acceptability of any existing criteria, such as InterQual criteria, Medicare guidelines or information from the medical literature.
- Administrative impacts to the health plan and providers.
- Market analysis or benchmarking, to determine whether the procedure is within the range of reasonable or accepted practice.
- Net cost savings, considering any possible administrative cost offset.

Criteria and Guidelines for Decisions

The criteria adopted by the plan are updated annually and include CMS Medicare Guidelines and also the following:

Criteria	Application
InterQual Acute – Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care – Sub-acute and Skilled Nursing Facility	• Sub-acute and skilled nursing facility admissions
InterQual Rehabilitation – Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care – Long-term Acute Care	• Long-term acute care facility admissions
InterQual Procedures – Adult	• Inpatient surgery and invasive procedures

Clinical Review Determination

In addition to reviewing clinical information, Blue MA evaluates the following:

- The member's eligibility coverage and benefits.
- The medical need for the service.
- The appropriateness of the service and setting.

If additional clinical information is required to approve the service, a Blue MA Care Management representative telephones the provider to ensure that all needed information is received in a timely manner, a written request may also be sent to the member, or provider receiving the authorization.

Clinical review required

Blue MA must review and approve select services before they are provided. The primary reason for clinical review is to determine whether the service is medically necessary, whether it is performed in the appropriate setting and whether it is a benefit. Clinical information is necessary for all services that require clinical review to determine medical necessity.

A complete list of the clinical criteria and required information that apply to each requested service can be found below:

- Acute Hospital Admissions (Notification required next business day).
- 14-Day Bundling for Re-admissions (Notification required next business day).
- Skilled Nursing Facility Admissions (Notification required before admission and before exhausted days for concurrent review).

- Long-Term Acute Care Hospital Admissions (Notification required before admission and before exhausted days for concurrent review).
- Inpatient Rehabilitation (Notification required before admission and before exhausted days for concurrent review).

Inquiries related to Clinical Review Determinations

Providers who wish to discuss a Clinic Review Determination may contact medical management, 800-240-0577. The Medical Information Specialist will gather information related to the inquiry. The call will be forwarded to a clinic staff person to review and discuss details with the provider clinical staff. If the request is to have a peer-to-peer conversation about the case, a call will be arranged with physician peer. If after the peer-to-peer conversation the Clinical Review Determination is upheld, the provider may begin the appeals process that is outlined in Chapter 15.

Submit the required clinical information with the initial review request

Providers are encouraged to submit the required clinical information with the initial request for clinical review sent via fax.

Clinical information for acute and post-acute hospital admissions can be submitted by faxing it to Care Management at 877-218-9089.

Blue MA is required by regulatory agencies and by Medicare to notify members as to what clinical information is needed to process a request for clinical review. When providers submit the clinical information with the initial request, it decreases the number of letters Blue MA is required to send to members.

Guidelines for Observations and Inpatient Hospital Admissions

Contracted facilities must notify Blue MA of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that Blue MA members receive care in the most appropriate setting, that Blue MA is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Blue MA of admissions by phone at 800-325-6201.

Post-service requests can also be initiated by contacting Blue MA Care Management.

Blue MA nurses conduct admission reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Blue MA nurses also speak to attending providers when necessary to obtain information.

Clinical information includes relevant information about the member in regard to the following:

- Health history
- Physical assessment
- Test and laboratory results
- Consultations
- Emergency room treatment and response
- Admitting orders

A copy of the form used to submit clinical information for inpatient acute can be found at bcbsks.com/documents/37-026-ma-pa-inpatient-hospital-assessment-2022-05-18.

Once authorization is obtained, the facility will be provided with an authorization number that is valid for the entire length of stay for the acute-care admission.

Emergency Admissions

When an admission occurs through the emergency room, Blue MA asks that the facility use best efforts to contact the primary care provider before admission or soon after admission to discuss the member's medical condition and to coordinate care.

Elective Admissions

Primary care and specialist providers are required to notify Blue MA at least 14 days before arranging elective inpatient, whenever possible.

Blue MA reviews the request to determine whether the setting is appropriate and, if required, meets criteria. Blue MA notifies the member, primary care provider, attending provider and facility of the determination.

Facilities must provide clinical information to Care Management within one business day of the elective admission.

Obstetrical Admissions

Blue MA requires facilities provide both admission and discharge information on deliveries via fax or phone to the Care Management Department. For all deliveries, the facility should notify Blue MA one day after discharge. The following information must be provided:

- Admission date, delivery date, and discharge date.
- Type of delivery.
- Whether the baby was born alive.
- Whether both mother and baby were discharged alive.

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services that are described as:

- The services include ongoing short-term treatment, assessment and reassessment.
- The services are furnished while a decision is being made regarding whether a member requires further treatment as a hospital inpatient or is able to be discharged from the observation bed.

Observation stays of up to 48 hours for members may be eligible for reimbursement when providers need more time to evaluate and assess a member's needs in order to determine the appropriate level of care. Examples (not all-inclusive) of diagnoses that may be treated in an observation setting include:

- Chest pain
- Syncope
- Cellulitis
- Pneumonia
- Bronchitis
- Pain or back pain
- Abdominal pain
- Pyelonephritis
- Dehydration (gastroenteritis)
- Overdose or alcohol intoxication
- Close head injury without loss of consciousness

Requirements for Observation Stays

Observation stays do not require any prior authorization or pre-notification requirements.

Options available beyond the observation period

For members who require care beyond the observation period, the options available are:

- Contact Care Management clinical staff to discuss alternate treatment options such as home care or home infusion therapy.
- Request an inpatient admission.

Note – If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should re-evaluate the member's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.

Medical necessity considerations – Inpatient vs. observation stays

When Blue MA members are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses. Here are some guidelines that clarify how medical necessity is determined:

- InterQual criteria is used to make determinations of medical necessity for all members.
- Blue MA does not require provider certification of inpatient status to ensure that a member's inpatient admission is reasonable and necessary. For Original Medicare patients, however, this certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B and 42 CFR 412.3.
- When the application of InterQual criteria results in a member's inpatient admission being changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- The clinical review process takes precedence ahead of the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures and the "two midnight" rule.

Review of inpatient re-admissions

Inpatient readmissions that occur within 14 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member has the same or a similar diagnosis are reviewed. Each re-admission is reviewed to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue.
- A lack of, or inadequate, discharge planning.
- A planned re-admission.
- Surgical complications.

In some instances, two admissions are combined into one for purposes of the DRG

reimbursement. Guidelines for bundling a re-admission with the initial admission are available at https://www.bcbsks.com/documents/guidelines-bundling-admissions.

Guidelines for submitting Skilled Nursing, Long-Term Acute Care, and Inpatient Rehabilitation Facilities

Facilities must notify Blue MA of all post-acute admissions and provide clinical information before the admission for initial requests and before the expiration of approved days for continued stay review requests. Timely notification helps ensure members receive care in the most appropriate setting, Blue MA is involved in the evaluation and coordination of discharge planning, and appropriate referrals to Case Management for members who need those services, including those managing active disease processes, those demonstrating high use of health resources, or those who are at high risk for health complications.

Providers should notify Blue MA of admissions by phone at 800-325-6201 or by fax at 877-218-9089.

Requests for transitional or discharge planning services are required to be handled during the business hours noted above.

In the event that an emergent need arises for these services after the hours noted above or on weekends or holidays, providers can call 800-331-0192 to reach an after-hours care manager.

Case Management nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Nurses also speak to attending providers when necessary to obtain information.

Clinical information includes relevant information about the member in regard to the following:

- Health history
- Prior Level of Functioning
- Clinical assessment
- Therapy Evaluations
- Admitting orders
- Discharge Plans

A copy of the form used to submit clinical information for post-acute admissions can be found at https://www.bcbsks.com/medicare/forms.

For post-acute admissions, if authorization is obtained, it will be valid for a defined length of time. If additional days are needed, a continued stay review will be required before the expiration of the initial approved days.

Prior authorization for behavior health services

All mental health and substance abuse inpatient admissions or concurrent reviews require prior authorization. This process includes acute detoxification admissions. Acute detoxification admissions are processed as a medical service and follow the same prior authorization requirements for in-patient admission. Blue MA partners with New Directions Behavioral Health (NDBH) to perform utilization and medical necessity determinations for behavioral health claims.

All mental health and substance abuse inpatient admissions or concurrent reviews should be submitted using WebPass. Services that require authorization through WebPass system include:

- Initial admissions for inpatient mental health/psychiatric and substance abuse services, including inpatient detoxification in behavioral health settings and inpatient ECT.
- Extensions of inpatient mental health/psychiatric and substance abuse services

Discharges should also be communicated through WebPass. Outpatient behavioral health services for Blue MA members do not require prior authorization.

NDBH may be reached at 877-589-1635 for general assistance with behavioral health services including:

- Arranging services or requesting authorization for services.
- Obtaining criteria used to make an authorization decision.

To access WebPass, go to ndbh.com, select provider, WebPass and either log in with a user name or request access by sending name, email, and Tax ID number to PRWebPass@ndbh.com.

Decision Criteria and Guidelines

Criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan or a combination of both. Individual circumstances of a member are taken into consideration when applying the criteria, as are characteristics of the local delivery system such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the network to support the member after discharge.

- Member's coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care, where needed.
- Ability of network hospital(s) to provide all recommended services within the established length of stay.

The review criteria are available to providers upon request by calling Care Management at 800-325-6201.

Discharge Planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member
- Family members
- Primary care provider
- Specialist
- Hospital discharge planning staff
- Ancillary providers, as necessary

Blue MA monitors all hospitalized members to assess their readiness for discharge and assist with post-hospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. Nurses work in conjunction with members' primary care providers to authorize and coordinate post-hospital needs, such as home health care, durable medical equipment, and skilled nursing placement. For these members, providers should follow the processes described in the "Guidelines for transitional care" section.

Note – Only acute care, skilled nursing long-term acute care, and inpatient rehabilitation facilities require prior authorization.

Standard Time Frames for Decisions

The Care Management staff conducts timely reviews of all requests according to the type of service requested. Decisions are made according to the following standard time frames:

Type of Request	Decision	Initial Notification	Written Notification	Type of Service
Pre-service urgent/concurrent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within three days of initial notification	Acute and Post-Acute Admissions
Pre-service non-urgent	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request	Part B Medications and members already admitted
Post-service	Within 30 days of receipt of request	N/A	Within 30 days of receipt of request	Services already provided

Requests for Information

Pre-service non-urgent requests – An extension of up to 14 calendar days is allowed if the member asks for the extension or if Blue MA needs more information to make a decision about the request. A provider can request an extension on the member's behalf by calling Care Management at 800-325-6201.

Post-service requests – An extension of up to 30 calendar days is allowed if Blue MA needs more information to make a decision.

If …	Then …
The service is approved.	For all service requests, the members and the providers receive written notification. Providers also will receive verbal notification for inpatient and post-acute services.
The service is denied.	Blue MA sends the member, provider, and facility a letter within the time frames stated above. The letter includes the reason(s) for the denial, informs the member and provider of their right to appeal, and explains the process. Blue MA also notifies the provider verbally of all denied determinations.

Steps to take before rendering services that are not or may not be covered

It is recognized that the member may consent to receive services that are not or may not be covered and therefore may be payable by the member. Providers are encouraged to verify member benefits before service.

To verify member benefits, please contact Provider Services 800-240-0577 or log on to Availity. From the Blue MA payor space, in the resource tab, select the Blue Medicare Advantage link.

Requesting an Expedited Decision

Either the provider or the member may request an expedited decision if they believe waiting for a standard decision could or would do one of the following:

- Seriously harm the life or health of the member.
- Seriously compromise the ability of the member to regain maximum function.
- Subject the member to severe pain that cannot be adequately managed with the care or treatment that is being requested.

Blue MA relies on the provider to determine conditions that warrant expedited decisions.

- If the provider requests an expedited decision, the decision is made according to pre-service urgent time frames.
- If the member requests an expedited decision, Blue MA calls the provider to determine whether the member's medical condition requires a fast decision.
  - If the provider agrees, Blue MA makes a decision to approve or deny the request according to pre-service urgent time frames (see "Standard time frames for members").
  - If the provider disagrees, Blue MA makes a decision according to standard time frames.
  - Blue MA will not make an expedited decision about payment for care the member has already received.

Expedited requests must be submitted during normal business hours 800-325-6201 and after hours by calling 800-331-0192.

How the provider may request an expedited decision?

Providers may request an expedited decision by calling Care Management at 800-325-6201.

Medical Necessity Considerations – General

As a Medicare Advantage organization, Blue MA is required by CMS to provide coverage to enrollees for all Original Medicare covered services. However, CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes as Original Medicare does for providers.

While medical necessity criteria do apply to determine coverage, the criteria do not have to be applied in the same manner as is required under Original Medicare. Specifically:

- Benefits – Medicare Advantage plans must provide or pay for medically necessary covered items and services under Part A (for those entitled) and Part B.

- Access – Medicare Advantage enrollees must have access to all medically necessary Part A and Part B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under Original Medicare.
- Billing and payment – Medicare Advantage plans need not follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures as long as providers, whether contracted or not, are paid accurately, in a timely manner and with an audit trail.

When determining medical necessity, both Blue MA and Original Medicare coverage and payment are contingent upon a determination that all three of the following conditions are met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury or to improve functioning of a malformed body member, or is a covered preventive service.

Members Held Harmless

In accordance with the provider agreement, providers may not seek payment from members for elective services that have not been approved by Blue MA through the organizational determination process or unless the member is informed in advance and has signed an Advanced Beneficiary Notice of Non-Coverage detailing the services that are not covered and the cost of the services to be rendered. Some of the circumstances in which members are held harmless for denied covered services include:

- Urgent/emergent admission denials.
- Partial denial of a hospital stay.
- Requests for elective services provided by contracted providers that require clinical review but were not forwarded to Care Management before the service being rendered.

Denials are issued for post-service requests for services provided by contracted providers when the information submitted is not substantiated in the medical record.

Members at Risk

In certain instances, members are held at financial risk for denied services. These instances occur when:

- The member's contract was not in effect on the date of service.
- The member refuses to leave an inpatient setting after the attending provider has discharged the member.
- A denial has been issued for pre-certified services.
- Services are rendered that are not a covered benefit under the member's certificate.
- Services are rendered at a non-contracted facility.

Medical Records Requests

Medical records may be requested to render a medical management decision or to investigate potential quality concerns. The member's contract allows review of all medical records. Blue MA must receive all records within 10 days of the request. Providers shall not charge a copying fee for medical records requested.

Emergency Room and Urgent Care Services

Emergent care defined

Members are provided coverage for emergency and urgent care services necessary to screen and stabilize their condition without pre-certification.

Emergency care definitions

Medical emergency – The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a member's health or pregnancy (in the case of a pregnant woman), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Accidental injury – A traumatic injury that, if not immediately diagnosed and treated, could be expected to result in permanent damage to the member's health.

Members should not be referred to emergency rooms or urgent care centers for services that can be performed in the primary care provider's office during regular business hours or that do not meet emergency or urgent care definitions.

Coordination of emergent and urgent care services

Members are encouraged to contact their primary care provider to assist in arranging urgent care services required after hours. Emergency and urgent care providers should send a written summary of the services provided and the treatment plan to the primary care provider within 30 days of the date of service.

Excessive use of emergency services

All members receive information on the appropriate use of emergency room services, as well as guidelines to follow when a situation does not require emergency care.

After-Hours Care Manager Program

Blue MA has care managers available after normal business hours, 6 p.m. to 8 a.m. Monday through Friday and all hours on weekends and holidays, with 24-hour service to assist providers and other providers for urgent requests.

Providers should call 800-331-0192 and follow the prompts to reach a care manager for any of the following needs:

- Determining alternatives to inpatient admissions and triaging members to alternate care settings.
- Coordinating and obtaining authorization for emergent service requests.
  Note – Pre-certifications for admission to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergent placement.

The after-hours care manager phone number can also be used after normal business hours to discuss any urgent or emergent determinations with a plan medical director. It should not be used to notify of acute care hospitalizations.

Admission notification should be done by fax or phone the next business day.

Appealing Care Management Decisions

Providers have the right to appeal any Initial Determination. The provider appeals process for Blue MA members is governed by Medicare regulations. For more information on the Appeals process, see Chapter 15: Appeals and Payment Disputes on pages 76-80.

Quality Improvement Organization

A Quality Improvement Organization (QIO) consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan.

The QIO for Kansas is Livanta, a Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO). BFCC-QIOs are responsible for medical case review, which supports the rights of people on Medicare. BFCC-QIOs assists Medicare patients with concerns about the care they have been receiving or if they want to request a review (appeal) of their discharge from a health care facility.

Contacting the QIO

Members may request a QIO review from Livanta if they disagree with the decision of an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency to discharge them.

Medicare beneficiaries may contact Livanta at 888-755-5580; 888-985-9295 (TTY). The Livanta website is: https://livantaqio.com/en/states/kansas

Member Appeal Rights for Hospital Discharge

Members who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe that coverage of their hospital stay is ending too soon.

Hospitals are required to notify all members who are admitted to the hospital of their hospital discharge appeal rights. Hospitals must issue the standard CMS form "An Important Message from Medicare About Your Rights" twice — the first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the member or of his or her representative and provide a copy.

Note – A link to the form An Important Message from Medicare About Your Rights is found at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/Important-Message-English-and-Spanish.zip.

Members have the right to appeal to the QIO for immediate review when a hospital and Blue MA, with provider concurrence, determine that inpatient care is no longer necessary.

Hospital discharge appeal process

If the member is dissatisfied with the discharge plan:

1. A member who chooses to exercise his or her right to an immediate review must submit a request to the QIO, following the instructions on the An Important Message from Medicare About Your Rights notice.
2. If Blue MA is driving the discharge, The QIO notifies the health plan that the member has requested an immediate review.
3. Blue MA or the facility is responsible for delivering to the member a Detailed Notice of Discharge as soon as possible, but no later than noon of the day after the QIO's notification. The standardized notice includes a detailed explanation of the reason that services are either no longer reasonable and necessary or are otherwise no longer covered. The Detailed Notice of Discharge must be completed and submitted by the entity that determines that covered services are ending, whether it is Blue MA or the facility.
4. Blue MA or the facility must supply any other information that the QIO needs to make its determination as soon as possible but no later than the close of business on the day that Blue MA notifies the facility of the request for information. This includes copies of both the "An Important Message from Medicare About Your Rights" notice and the "Detailed Notice of Discharge" and written records of any information provided by phone.
5. The QIO makes a determination and notifies Blue MA, the member, the hospital, and the provider of its determination within one calendar day after it receives the requested information.
6. Blue MA continues to be responsible for paying the costs of the member's stay until noon of the next calendar day following the day that the QIO notifies the member of their coverage decision.
7. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal.

Member responsibilities related to hospital discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to hospital discharges.

If …	Then …
The QIO agrees with the doctor's discharge decision.	The member is responsible for paying the cost of his or her hospital stay beginning at noon of the calendar day following the day that the QIO notifies the member of the coverage decision.
The QIO disagrees with the doctor's discharge decision.	The member is not responsible for paying the cost of additional hospital days, except for certain convenience services or items not covered by KPBMA.

Circumstances in which the immediate review process does not apply

The immediate review process does not apply in these circumstances:

- To care provided in a provider clinic
- To observation care
- To inpatient-to-inpatient transfers
- To admissions for services that Medicare never covers
- When the member has exhausted all of his or her Medicare days

QIO immediate review of SNF, CORF and HHA discharges

Special expedited appeal rights for members being discharged from SNF, CORF or HHA services

Members receiving skilled nursing facility care, home health agency services or services at a comprehensive outpatient rehabilitation facility, have special appeal rights that allow an expedited review if they disagree with the decision to end covered services.

The Medicare form Notice of Medicare Non-Coverage (NOMNC) is delivered to members by the providers of SNF, HHA, or CORF services in one of the following situations:

- When medical necessity criteria are no longer met and no additional days are authorized by Blue MA or the facility/Provider.
- At least two days before a scheduled discharge date.

The NOMNC contains detailed instructions about how members may request an immediate appeal directly to the QIO if they disagree with the decision to end services.

The NOMNC Appeal Process

Medicare regulations require the provider to deliver the standard NOMNC to all members when covered services are ending, whether or not the member agrees with the plan to end services. Here's how:

1. The provider delivers the NOMNC to members at least two calendar days before coverage ends. If the member is receiving home health agency services and the span of time between services exceeds two days, the provider may deliver the NOMNC at the next-to-last time that services are furnished. The form must be delivered whether or not the member agrees with the plan to end services.

   Special considerations related to delivery of the NOMNC:

   - Providers are encouraged to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.
   - If services are expected to be less than two days in duration, the provider may deliver the NOMNC at the start of service. A member who receives the NOMNC and agrees with the termination of services before the end of the two days may waive the right to request the continuation of services.
   - If the member is not mentally competent to receive the notice, the provider must deliver it to the member's authorized representative.
2. The provider requests that the member sign and date the NOMNC, acknowledging receipt of his or her appeal rights. If the member refuses to sign the form, the facility must record the date and time it was delivered to the member.
3. The provider must fax the signed NOMNC for Skilled Nursing Facilities only back to Care Management at 877-218-9089, Attention: Medical Records.
4. The provider is expected to retain a signed copy of the NOMNC form with the member's medical record. The member is responsible for contacting the QIO by noon of the day before services end if he or she wishes to initiate an expedited review by following the detailed instructions on the form.
5. When the member initiates an expedited review, the Detailed Explanation of Non-Coverage is delivered to the member by the close of business on the same day that the QIO is notified of the member's request for appeal. The DENC provides specific and detailed information as to why the member's SNF, HHA, or CORF services are ending.

   Note – The DENC must be completed and submitted by the entity that determines that covered services are ending, whether it is Blue MA or the SNF, HHA, or CORF provider.

6. Blue MA may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.
7. A copy of the DENC is also sent to the QIO
8. The expedited review process conducted by the QIO is usually completed within 48 hours. The provider, the member, and Blue MA are notified of the decision by the QIO.
9. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from Blue MA.

Other considerations in the NOMNC process

Providers should also be aware of the following when notifying a member that his or her services are ending:

- Contracted facilities should be using the appropriate NOMNC forms. Providers should insert their name, address and phone number in the spaces provided at the top of the form.
- Blue MA may issue a next review date when authorizing SNF services. The next review date does not mean further coverage is denied.
- Providers should submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, Blue MA will allow for two additional days for the provider to supply
- The member with the NOMNC. The form should only be given to members when SNF criteria are no longer met and no further days are authorized or two days before a scheduled discharge date.
- If there is a change in the member's condition after the NOMNC is issued, both Blue MA and providers should consider the new clinical information. If there is a change in the effective date that coverage ends, the provider should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.

Member Responsibilities when appealing SNF, CORF, or HHA Discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to discharges from SNF, CORF, or HHA services.

If …	Then …
The QIO agrees with the doctor's decision to end covered services.	The member is financially responsible for services on the date indicated on the NOMNC.
The QIO disagrees with the doctor's decision to end covered services.	Blue MA will continue to cover the services.

Chapter 14: Health Education & Management Program

Blue MA has developed a chronic condition management program to help members manage chronic diseases through a partnership among providers, members and the plan.

Health care management strategies include education about staying healthy and living with an illness. The objective of these strategies is to improve clinical outcomes, reduce costs and improve member and provider satisfaction.

Goals for chronic condition management

Members with chronic conditions are identified and may benefit from chronic condition management interventions designed to:

- Promote early diagnosis and appropriate treatment according to recognized clinical practice guidelines.
- Provide tools to simplify member self-management efforts.
- Improve member adherence to a treatment plan.
- Provide continuity of care through specialty Case Management when indicated.
- Integrate health promotion and wellness initiatives across the continuum of care.
- Educate members about the purpose and importance of advance directives Blue MA's role in chronic condition management includes:
  - Analyzing plan data and targeting conditions appropriate for program development
  - Researching, developing and distributing clinical practice guidelines
  - Developing and implementing comprehensive chronic condition management programs
  - Using predictive modeling to determine individual member interventions
  - Mailing educational materials to members about self-management, preventive health issues, relevant medical tests, lifestyle issues and medication compliance.
  - Offering registered nurse chronic condition managers who make outreach calls to identified members.
  - Providing educational resources to providers.
  - Studying outcomes to determine the impact of chronic condition management programs.

Member Participation

Members identified as eligible for specific chronic condition management programs are automatically enrolled (member identification criteria are consistent with clinical practice guidelines). Members can decline participation in a program at any time.

Source of Information	Description
Health Education & Management Program 800-240-0577, 8 a.m. to 6 p.m. Monday through Friday (except holidays)	A toll-free number staffed by experienced registered nurses. Blue MA encourages members and providers to ask questions and request additional information.

Health Risk Assessments

A health assessment completed by the member is encouraged as part of an annual wellness visit for Medicare Advantage members, according to the Patient Protection and Affordable Care Act and CMS.

The form is mailed to the member and asks the member complete it and return it to Scantron, the Blue MA vendor, for processing. Members receive a response letter outlining topics they should discuss with their provider.

Providers should also remind patients to bring a copy of their member health assessment or the response letter to their annual wellness visit. The results of the member's health assessment need to be available during the wellness visit so they can be considered when a care plan is created.

Quality Management

All Medicare Advantage (MA) organizations are required to have a quality improvement (QI) program as described in the federal regulations at 42 CFR §422.152, "Quality improvement program". The requirements for the PDP Quality Assurance program are based in regulation as per 42 Code of the Federal Regulations § 423.153(c).

The primary goal of the MA organization's QI program is to effect sustained improvement in patient health outcomes. As provided under 42 CFR §422.152(c) and §422.152(d), KPBMA's QI program must include at least one chronic care improvement program (CCIP) for one chronic condition and a quality improvement project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

Obtaining a Pre-Service Organization Determination

(Not related to services or items requiring prior authorization)

Providers may choose to obtain a written pre-service organization determination from us before providing a service or item.

All Blue MA plans provide at least the same level of benefit coverage as Original Medicare. If the service or item provided meets Original Medicare medical necessity criteria, it will be covered subject to the member cost share and the terms and conditions of the member's plan.

When the claim is submitted, it must still meet eligibility and benefit guidelines to be paid.

To request a pre-service organization determination, print the form from the website by clicking on the appropriate link Organization Determination Form and submit your request with supporting medical documentation by fax to 800-976-2794 Attn: Organization Determination Request or mail to Attn: Organization Determination Request, PO Box 261323, Plano, TX 75026-1323.

A decision will be made and notification will take place within 14 days of receiving the request, with a possible 14-day extension either because of the member's request or justification that the delay is in the member's best interest.

In cases where waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, expedited determination can be requested. To obtain expedited determination, fax the request indicating "Urgent" or "Expedite" on the first page. Notification of the decision will take place within 72 hours unless a 14-day extension is requested and is in the best interest of the member.

Be sure to include the following information with your request for an advance coverage determination:

- Provider or supplier contact information including name and address.
- Anticipated date of service, if applicable.
- Procedure/HCPCS and Diagnosis codes.
- Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and provider specialty.
- Documentation and any correspondence that supports your position that the plan should cover the service or item (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation).
- Name and signature of the provider or provider's representative.

Network exception

Members may have a higher cost-share for services or items received from an out-of-network provider. Providers have the option of requesting a network exception for specialized services when there is limited or no access to network providers.

To request a network exception, print the form from the website by clicking the Organization Determination Form link and submit your request in writing by fax to 800-976-2794 or mail to PO Box 261323, Plano, TX 75026-1323.

Exceptions – Emergency care, urgently needed services when the network is not available, and out-of-area dialysis services.

Chapter 15: Appeals and Payment Disputes

Pre-Service Appeals/Organization and Coverage Determinations

Providers may appeal on behalf of the member if they are dissatisfied with an Initial Determination of a service or item that has not been provided.

Providers should follow the following guidelines when submitting an appeal for pre-service requests:

1. Part C – Call Provider Services at 800-240-0577.
   Part D – Call Prime Customer Service at 866-230-7265.
   The majority of provider disputes can be resolved with a quick phone call.
2. Submitting a First-Level Appeal – A provider unsatisfied with the decision can submit a First-Level Appeal within 60 days of the Initial Determination. Kansas providers appealing non-Kansas claims should submit appeals directly to the Kansas plan. While non-Kansas providers should submit Part C appeals to their local Blue Plan. The appeal – which should include appropriate supporting documentation – should be submitted to:

Appeal Type	Appeal/Dispute by Phone	Appeal/Dispute by Fax	Appeal/Dispute by Mail
Part C	800-240-0577	800- 976-2794	Blue MA Provider Correspondence PO Box 260875 Plano, TX 75026-0875
Part D	866-230-7265	888-285-2242	Prime Therapeutics LLC Attn: Medicare Appeals Department 10802 Farnam Drive Omaha, NE 68154

The appeal will be reviewed and responded to within the following time frames:

Type of Appeal	Medical (Part C)	Medical (Part C) with Extension	Pharmacy (Part D)
Standard	30 days	44 days	7 days
Expedited (see page 62)	72 hours	17 days	72 hours

3. Submitting a Level 2 Appeal- All partially favorable or adverse medical (Part C) First-Level Appeals are automatically sent to an Independent Review Entity (IRE) for a Second-Level Appeal. A provider or member does not have to request the appeal.
   For partially favorable or adverse pharmacy (Part D) First-Level Appeals, the member and/or prescribing provider will be notified and informed of the right to a Second-Level Appeal. The pharmacy (Part D) Second-Level Appeal – which should include appropriate supporting documentation AND a copy of the First-Level Appeal decision – can be submitted within 60 days to the fax or mail address listed above.

The Second-Level Appeals will be reviewed by an IRE and responded to within the appropriate time frame:

Type of Appeal	Medical (Part C)	Pharmacy (Part D)
Standard	30 days	7 days
Expedited (see page 62)	72 hours	72 hours

4. Subsequent appeals are available if the Amount in Controversy (AIC) is greater than or equal to $170.
5. Third-, Fourth, and Fifth-Level Appeals – If the amount in controversy (AIC) is greater than or equal to $170, the provider and member have subsequent appeal rights for medical (Part C) services, while only members have subsequent appeal rights for pharmacy (Part D) services. The Third-Level Appeal is an Administrative Law Judge (ALJ) hearing and must be filed within 60 days of Second-Level Appeal notification. The Fourth-Level Appeal is a Medicare Appeals Council and must be filed within 60 days of the Third-Level Appeal notification. The Fifth-Level Appeal is a Federal Court Judicial Review, is only allowed if the AIC is greater than or equal to $1,670, and must be filed within 60 days of the Fourth-Level Appeal notification.

Post-Service Appeals and Payment Disputes

Providers have appeals and payment dispute resolution rights if they are dissatisfied with an Initial Determination. Both contracting and non-contracting providers may dispute determinations on denied claims, such as denial of a service related to medical necessity and appropriateness.

Blue MA Providers should follow the following guidelines when submitting an appeal for Part C claim denials and payment disputes:

1. Call Provider Services – 800-240-0577. The majority of provider disputes can be resolved with a quick phone call.
2. Submitting a First-Level Appeal – A provider unsatisfied with the decision can submit a First-Level Appeal within 60 days of the Initial Determination. The appeal – which should include appropriate supporting documentation – should be submitted to:

Appeal/Dispute by Phone	Appeal/Dispute by Fax	Appeal/Dispute by Mail
800-240-0577	800-976-2794	Blue MA Provider Correspondence PO Box 260875 Plano, TX 75026-0875
Kansas providers appealing non-Kansas MA member claims should submit appeals directly to the Kansas plan. Non-Kansas providers should submit Part C appeals to their local Blue plan.		

The First-Level Appeal will be reviewed and responded to within 60 days of receipt.

3. Submitting a Second-Level Appeal – A provider unsatisfied with the First-Level Appeal decision can submit a Second-Level Appeal within 60 days of the Initial Determination. The appeal – which should include appropriate supporting documentation – should be submitted in writing to:

Appeal/Dispute by Fax	Appeal/Dispute by Mail
800-868-6438	Blue MA Provider Second-Level Appeals PO Box 261323 Plano, TX 75026-1323
Kansas providers appealing non-Kansas MA member claims should submit appeals directly to the Kansas plan. Non-Kansas providers should submit Part C appeals to their local Blue plan.	

The decision from the Second-Level Appeal will be final and binding.

4. Appropriate supporting documentation needed for First- and Second-Level Part C Appeals includes:
   - Provider or supplier contact information including name and address.
   - Pricing information, including NPI number (and CCN or OSCAR number for institutional providers), ZIP code where services were rendered, and provider specialty.
   - Reason for dispute, a description of the specific issue.
   - Copy of the provider's submitted claim with disputed portion identified.
   - Documentation and any correspondence that supports your position that the plan's denial was incorrect (including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation, and interim rate letters when appropriate).
   - Appointment of provider or supplier representative authorization statement, if applicable.
   - Name and signature of the provider or provider's representative.
   - Waiver of Liability

Non-contracted providers should follow the above First- and Second-Level Appeals processes for Part C payment disputes. Both levels should be submitted to BCBSKS. Non-contracted providers appealing Part C claim/medical necessity denials may submit an appeal in writing to:

Appeal/Dispute by Fax	Appeal/Dispute by Mail
800-868-6438	Blue MA Provider Second-Level Appeals PO Box 261323 Plano, TX 75026-1323

The appeal must include a signed Waiver of Liability. The Waiver of Liability indicates that you formally agree to waive any right to payment from the member for the service in question regardless of the outcome of the appeal.

The Waiver of Liability can be found at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip.

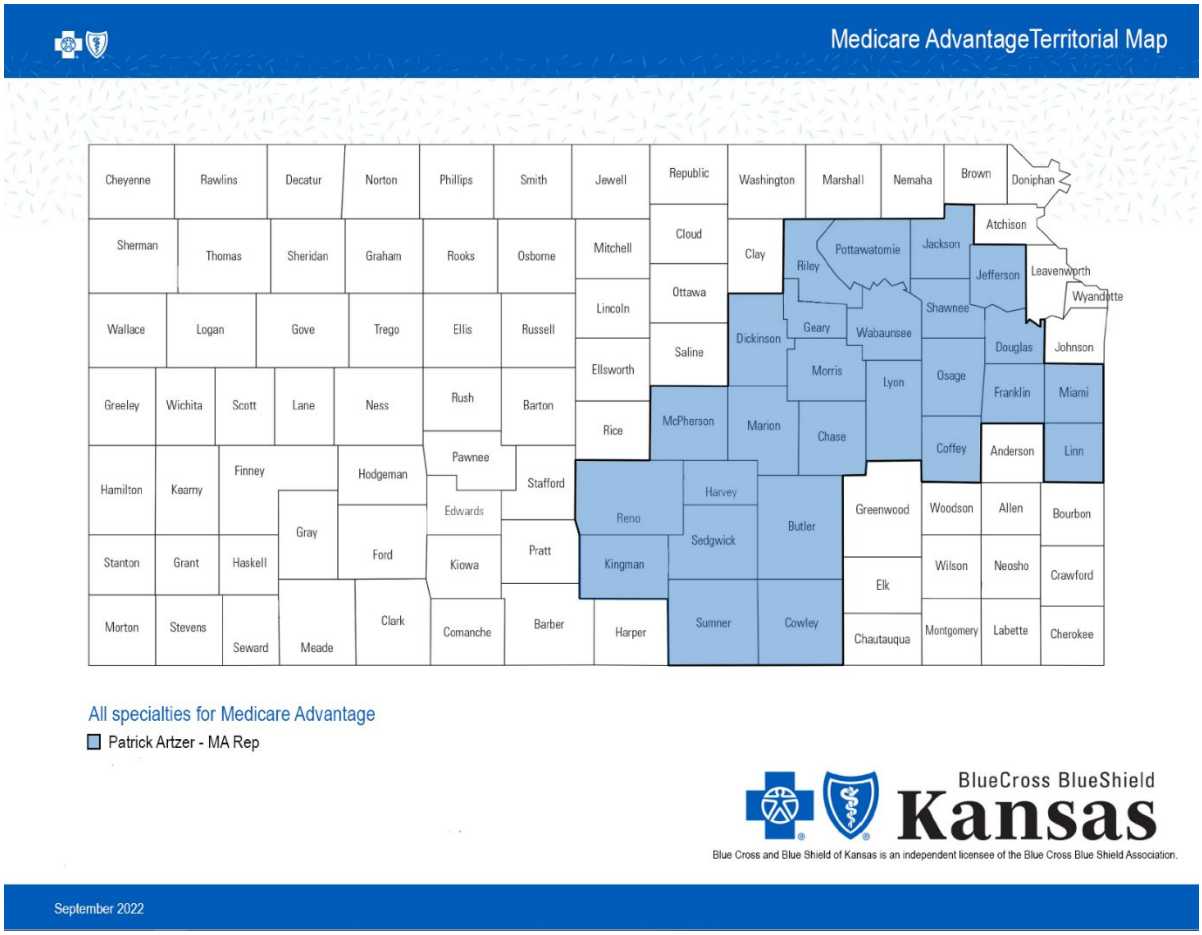
Questions, additional information and contacts

If you have general questions about BCBSKS Medicare Advantage, call Provider Services at 800-240-0577 (8:00 a.m. to 6:00 p.m.) For questions regarding BlueCard MA claims, call customer service at 800-432-3990 (7:00 a.m. to 4:30 p.m.)

Medicare Advantage Professional Relations contact information

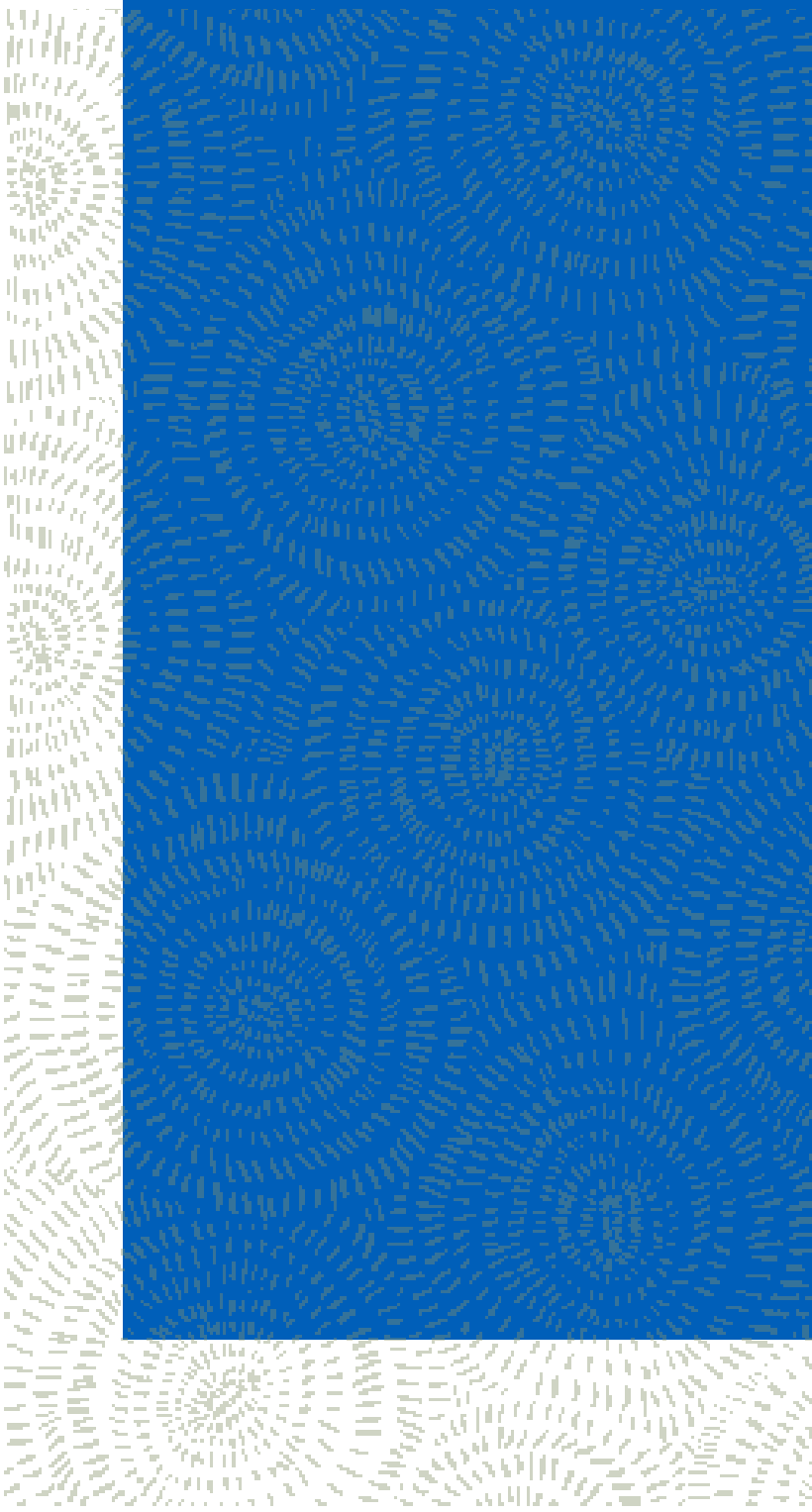
Topeka

- Patrick Artzer, 800-432-0216 ext. 6289, 785-291-6289, Patrick.Artzer@bcbsks.com
- Provider Network Services, 800-432-3587, 785-291-4135, option 1 or 3, prof.relations@bcbsks.com



Revisions

01/01/2020	Introduced manual
10/20/2020	Page 6 – Added Host Customer Service contact information
10/20/2020	Page 17 – Adjusted language regarding interim rate letters
06/15/2021	Page 77&78 – Clarified language on the appeal process
	Page 31 – Added prompt pay exclusions
07/27/2021	Page 17 – Added cost settlement information
08/25/2021	Page 79&80 – Clarified language on Post-Service Appeals and Payment Disputes
03/09/2022	Page 8 – Updated image of ID cards
	Page 15 – Updated the Medical Policy Hierarchy section
	Page 16 – Added language on RHC reimbursement rate
	Page 33 – Added language and link for Specific Billing Guidelines
03/01/2023	Page 4 – Chapter 1, updated counties listed
	Page 12 – Updated information about if you have questions for claim status or plan payments under, Where to submit a claim section
	Page 13 – Added DME, P&O, medical suppliers and pharmacists section
	Page 13 – Added Federally Qualified Health Center to the Rural Health Clinic Billing section
	Page 14 – Updated Coordination of Benefits section to reflect current practices
	Page 15 – Added Claims for unlisted and Not Otherwise Classified (NOC) Procedure Codes section
	Page 18 – Updated Medical Policy Hierarchy section to reflect current processes
	Page 19 – Updated Chapter 4: Claims Payment, Refunds, and offsets Reimbursement Methodology section to include information on reimbursement for RHC and FQHC
	Page 19 – Updated bullet regarding Services Coded with NOC Codes to reflect current practices
	Page 20 – Added Settlement information to Critical Access Hospitals and Rural Health Clinics section
	Page 21 – Updated Billing section to reflect current practices
	Page 22 – Added last two bullets to the co-pays section
	Page 23 – Updated Explanation of Payment section to reflect current practices
	Page 29 – Updated information under header, Other Medical Record Requirements to reflect current practices and add clarification
	Page 38 – Updated second bullet on page to reflect current practices
	Page 45 – Updated Requests to Term from Blue MA header to reflect how we must receive the request
	Page 49 – Updated the HEDIS measure that are listed to reflect current measures
	Page 51 – Updated CMS Star Ratings section to reflect current number of measures
	Page 53 – Added 2023 CMS Quality Star Measures header and information
	Page 54 – Updated Helpful Links to reflect current links and information
	Page 59 – Updated the Clinical Review required header to reflect current information by removing last bullet
	Page 85 – Added section Questions, Additional Information, and Contacts



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