Medicare Advantage Office Administrative Manual

Updated 2011

South Carolina

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Introduction

Medicare Blue[SM], Medicare Blue[SM] Plus and Medicare Blue[SM] Saver are Medicare Advantage products offered by BlueCross BlueShield of South Carolina. These plans offer a network of preferred providers, and members can receive benefits both in and out of network. BlueCross BlueShield of South Carolina Medicare Advantage plans offer benefit choices for enrolled members, including medical coverage only (Medicare Blue Saver) and both medical and prescription drug (Part D) coverage (Medicare Blue and Medicare Blue Plus).

Purpose of This Guide

This manual serves as a reference for providers participating in the BlueCross BlueShield of South Carolina Medicare Advantage Network.

Section 1: Contact Information

External Contact Information

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Section 2: Our Plans

Types of Medicare Advantage Plans

BlueCross BlueShield of South Carolina offers three individual Medicare Advantage plans to Medicare-eligible recipients in South Carolina. It also serves as administrator for two employer-sponsored plans (Richland County and Spartanburg County). All five plans are preferred provider organization (PPO) plans. Providers should confirm the level of coverage for all Medicare Advantage members before providing services. Level of benefits and coverage rules may vary.

Individual Plans

- Medicare Blue
- Medicare Blue Plus
- Medicare Blue Saver

Employer Sponsored Group Plans

- Richland County Medicare Blue℠
- Spartanburg County Medicare Blue℠

Member Identification (ID) Card Information

Each ID card shows:

- The member's personal identification number
- The "ZCT" alpha prefix (as the first three characters of the ID number)
- The ID number sequence that must be included with each claim submission
- The plan name (Medicare Blue, Medicare Blue Plus, Medicare Blue Saver, Richland County Medicare Blue, Spartanburg County Medicare Blue)

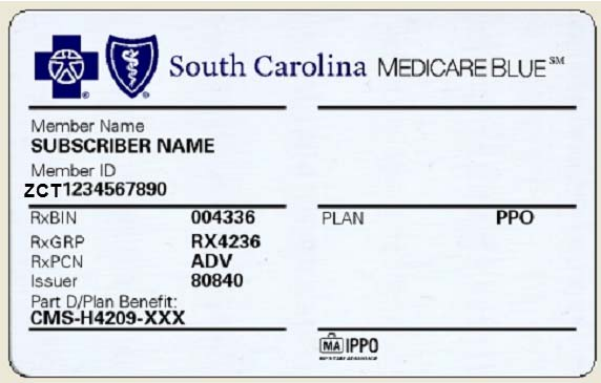
Make a copy of the front and back of each patient's ID card. Make sure that billing staff has access to the complete ID number shown on the card. If the entire ID number, including the three-digit alpha-prefix, is not captured and submitted correctly, providers may experience a delay in claim processing.

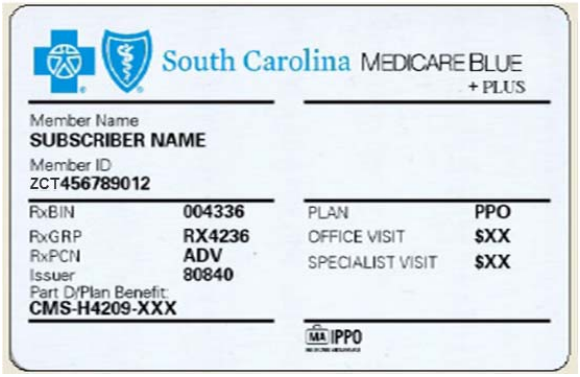
Remember: Do not use a member's Social Security Number for filing claims.

An ID card does not ensure current eligibility. Providers can verify eligibility by telephone or by submitting a HIPAA-compliant electronic transaction request.

Medicare Blue and Medicare Blue Plus
Medicare Blue and Medicare Blue Plus are Medicare Advantage PPO plans that combine the benefits of traditional Medicare with Medicare Part D prescription drug coverage. Members can go to any network doctors, specialists or hospitals for in-network benefits. A member can choose an out-of-network provider, but he or she may have to pay more for services.

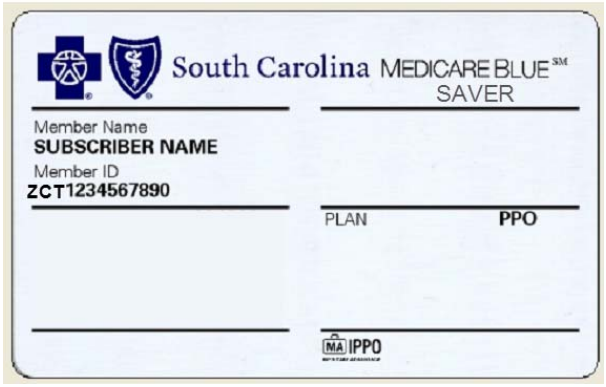
Sample Medicare Blue and Medicare Blue Plus ID Cards





Medicare Blue Saver
Medicare Blue Saver is a Medicare Advantage PPO plan that provides benefits for traditional Medicare-covered services without Medicare Part D prescription drug coverage.

Sample Medicare Blue Saver ID Card



Richland County Medicare Blue
Richland County Medicare Blue is a Medicare Advantage PPO plan that combines the benefits of traditional Medicare with Medicare Part D prescription drug coverage. Members can go to any network doctors, specialists or hospitals for in-network benefits. A member can choose an out-of-network provider, but he or she may have to pay more for services.

Spartanburg County Medicare Blue

Spartanburg County Medicare Blue is a Medicare Advantage PPO plan that combines the benefits of traditional Medicare with Medicare Part D prescription drug coverage. Members can go to any network doctors, specialists or hospitals for in-network benefits. A member can choose an out-of-network provider, but he or she may have to pay more for services.

Section 3: General Coverage Information

General Coverage Information

Here is a summary of Centers for Medicare and Medicaid Services (CMS) requirements applicable to BlueCross Medicare Advantage benefit plans. Find details on specific benefits and cost sharing included in each Medicare Advantage plan by visiting www.SouthCarolinaBlues.com, going to the Providers section and clicking on the Medicare Advantage link..

All BlueCross Medicare Advantage benefit plans must offer coverage that:

- Imposes no waiting periods or exclusions from coverage due to pre-existing conditions
- Covers ambulance services dispatched through 911 or a local equivalent for which other means of transportation would endanger the member's health (42 CFR 410.40)
- Covers all services without prior authorization, whether the members get these services from network or non-network providers [42 CFR 422.112 (b); 422.100 (b)]
- Covers maintenance and post-stabilization care services. Benefits include covered services related to an emergency medical condition and which are provided after the member is stabilized either to maintain the member's stabilized condition or, under certain circumstances, to improve or resolve the member's condition.
- Covers renal dialysis services for members temporarily outside of the plan's service area [422.100(b) (1) (iii)]
- Includes benefits for screening mammography, influenza vaccinations and other CMS-required preventive services without a referral
- Applies no copayments or other cost-sharing for CMS-approved preventive services including, but not limited to, influenza vaccinations [422.112(a) (3) [422.100(h) (1)] [422.100(h) (2)]
- Offers a network of providers that allows sufficient access to covered services, according to CMS standards [422.112(a) (1)]
- Provides benefits in a manner consistent with professionally recognized standards of health care [422.504(a) (3) (iii)
- Makes covered services available to members through office hours or telephone service, 24 hours a day, seven days a week [422.122(a)(8)]

BlueCross plans must provide benefits for covered services without referral or prior authorization requirements when the services are provided by in-network and out-of-network eligible providers.

Section 4: Provider Roles & Responsibilities

Provider Agreement

The Provider's Agreement specifies obligations for participation in the BlueCross Medicare Advantage PPO network including, but not limited to:

- Payment for services covered by BlueCross Medicare Advantage plans
- Reporting and disclosure requirements
- Accountability
- Claims turnaround time

Unless otherwise prohibited by federal or state laws and regulations, BlueCross Medicare Advantage network providers agree to refer members to other BlueCross Medicare Advantage PPO network providers, whenever possible, to receive covered services. When a transfer is medically necessary, network hospitals agree to move patients to other BlueCross Medicare Advantage network hospitals, when possible.

If a member chooses to seek out-of-network services when in-network services are available, higher out-of-network cost sharing will apply even if the member has a referral from a network provider. To find a BlueCross Medicare Advantage network provider, access the online provider directory at www.SouthCarolinaBlues.com. From the Members section, click Find a Provider.

Provider Anti-Discrimination

In selecting practitioners to participate in the Medicare Advantage provider network, BlueCross may not discriminate, in terms of participation, reimbursement or indemnification, against any health care professional acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification in terms of participation, reimbursement or indemnification.

This prohibition does not preclude:

- The refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees.
- The use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- Implementation of measures designed to maintain quality and control costs consistent with BlueCross's responsibilities.

Provider Credentialing

BlueCross Medicare Advantage cannot employ or contract with individuals excluded from participation in Original Medicare. BlueCross verifies each provider's Medicare status during credentialing and recredentialing processes, and periodically outside of the credentialing cycle.

Medicare Advantage Information	
Credentialing Required For:	
Specialty Types	
MD	Yes
DO	Yes
Oral Surgeons DDS	Yes
DC	Yes
PhD	Psychologists
OD	Yes
Dentists DDS, DMD	Yes
Audiologists	Yes
Allied Licensed Independent Practitioners:	
PT	Yes
OT	Yes
ST	Yes
NP and other APRN specialties such as CNM, CRNA, etc.	Yes
PA	Yes
RNC	No
LCSW	No
LISW	Yes
LICSW	No
LPC	Yes
LMFT	Yes
LMHC	No
LPCC	No

Recredentialing

BlueCross requires recredentialing every three years for Medicare Advantage network providers. See Section 6 of this manual, Medical Management and Quality Improvement, for more information about responsibilities of network providers.

Non-Acceptance and Termination

If BlueCross declines to include a provider or group of providers in the Medicare Advantage network, BlueCross will furnish written notice to the affected provider(s) including the reason for the denial decision.

If a provider chooses to terminate participation with BlueCross Medicare Advantage, the provider must follow contractual termination provisions. CMS requires providers to give at least 60 days' notice to BlueCross when terminating participation without cause. BlueCross will notify all affected members of the termination of a provider contract within 30 days of receiving notice of termination. BlueCross will notify the provider in writing of reasons for any suspension or termination from network participation.

Section 5: Member Rights & Responsibilities

Eligibility and Enrollment

While Medicare beneficiaries choose to enroll in or disenroll from a BlueCross Medicare Advantage plan, federal government regulations limit when and how beneficiaries can make plan elections. Requirements specify when beneficiaries may make plan elections and the limits on the number of elections they may make each year.

Medicare beneficiaries may enroll in a BlueCross Medicare Advantage plan when: (a) they are covered by both Medicare Parts A and B, (b) they continue to pay the Part B premium, and (c) they meet other eligibility requirements. Federal regulations permit Medicare Advantage members to disenroll from Medicare Advantage plans by:

- Submitting a completed disenrollment form to the BlueCross Medicare Advantage Operations department during a valid election period
- Submitting a signed letter requesting disenrollment to the BlueCross Medicare Advantage Operations department during a valid election period
- Contacting any Social Security or Railroad Retirement Board office

BlueCross must disenroll members if they:

- Lose Part B of their Medicare benefits
- Move outside the service area permanently
- Reside outside the BlueCross Medicare Advantage service area for six consecutive months or more
- Fail to pay monthly premiums

In most cases, disenrollment requests BlueCross receives on or before the last business day of the month will be effective on the first day of the following month. Election period rules and limits apply.

BlueCross may also disenroll members for failure to fulfill member responsibilities, including the responsibility to be courteous and respectful to providers, staff and fellow patients.

Provider's Advice & Advocacy

BlueCross may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is a Medicare Advantage patient. Such advice may pertain to:

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

Providers must provide information about treatment options in a culturally competent manner, including the option of no treatment. Health care professionals must ensure that disabled Medicare Advantage members have access to effective communications throughout the health system in making decisions about treatment options.

HIPAA Privacy Information

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, BlueCross discloses only the minimum necessary Protected Health Information (PHI) related to a member's treatment, for payment determination of claims and for the plan's health care operations. Likewise, providers submitting information to BlueCross should send only minimum necessary information to complete the task. For example, a provider should remove or cover other patient information on a payment register that contains information not related to the inquiry.

BlueCross must verify the identity of all who request information concerning a member's PHI. Information used to verify identity for provider inquiries includes the provider's identification number, tax identification number and first name. The caller's department or position title assists BlueCross in accurately documenting each inquiry.

Discrimination Prohibited

Discrimination against BlueCross Medicare Advantage members based on health status is prohibited [42 CFR 422.110(a)]. BlueCross may not deny, limit or condition coverage or benefits to individuals eligible to enroll in a BlueCross Medicare Advantage plan based on any factor related to the member's health status including, but not limited to:

- Medical condition, including mental as well as physical illness (except for ESRD status)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

BlueCross may not enroll any individual in a BlueCross Medicare Advantage plan who has been diagnosed with End Stage Renal Disease (ESRD). Members who develop ESRD after enrolling may remain members.

BlueCross and its contracted providers must comply with the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act of 1973, the Americans with Disabilities Act and applicable federal funds laws 42 CFR [422.504(h) (l)]. BlueCross and Medicare Advantage network providers may not discriminate against a member with respect to the delivery of health care services consistent with the benefits covered in the member's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

Member Protections

Federal regulations establish protections for Medicare Advantage members.

Providers may not distribute marketing or other member materials describing BlueCross Medicare Advantage plans unless CMS and BlueCross approve the materials in advance (if CMS requires approval for the specific type of material). BlueCross employees or representatives and network providers must follow all CMS Medicare Advantage marketing guidelines, including those applicable to health fairs. Providers who want to display or distribute any information about BlueCross Medicare Advantage plans or benefits must first contact Provider Services to request approval.

If needed, providers shall cooperate with BlueCross to ensure that each member completes the required initial assessment of his or her health care needs within 90 days after the effective date of initial enrollment. Generally, members are able to complete the Health Risk Assessment required by CMS without the assistance of a physician.

Providers shall provide covered services to members in a manner consistent with professionally recognized standards of health care.

Providers may not bill or accept payment from members for any services BlueCross determines are not medical necessity according to BlueCross Medicare Advantage medical necessity guidelines unless: (a) the provider specified prior to the service being rendered that the service was not medically necessary, and (b) the member agreed, in writing, to pay for the service.

Providers cannot hold any member liable for payment of any fee that is the legal obligation of a BlueCross Medicare Advantage plan or an amount that exceeds the contractually allowed amount.

Providers must continue to provide covered services to members for the duration of the contract period for which CMS has made payments to BlueCross Medicare Advantage plans. In the event that (a) BlueCross's contract with CMS terminates, or (b) BlueCross Medicare Advantage plans become insolvent, participating providers must continue to provide covered services to all hospitalized members through the date of discharge.

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

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of benefits decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. Providers may be required to furnish a copy of any NOMNC to BlueCross upon request. For copies of the notice and the notice instructions, go to http://www.cms.gov/MMCAG/Downloads/NOMNCInstructions.pdf.

BlueCross Medicare Advantage members may appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility benefits within the time frames specified by law.

Section 6: Medical Management and Quality Improvement

Medical Management

The provider's participation agreement with BlueCross requires compliance with our medical management programs. BlueCross designed medical management programs to ensure that the treatment members receive is covered according to the medical necessity guidelines in their contracts. Medical management programs also encourage cost effective and appropriate use of the health care delivery system.

Medical Management programs include:

- Case management
- Disease management

Objectives of the programs are to:

- Promote efficient use of health care resources
- Define and agree upon appropriate standards of care

The medical management process is a review for medical necessity only. Payment for services remains subject to all terms of the member's benefit plan as approved by (CMS). Therefore, denials may occur because the benefit plan does not cover a service or the member is not eligible at the time a service is provided.

BlueCross recommends that providers verify coverage, benefits, contract eligibility and limitations for all patients prior to providing services.

BlueCross does not require prior authorization and/or admission review for the services to be covered. Providers, however, remain financially liable for services they provided that BlueCross later determines are not medically necessary and/or investigational.

Case Management
Licensed health care professionals (registered nurses, social workers) provide case management services by phone. These case managers coordinate health care services and manage benefits with members and providers. Case managers work with members who have chronic, complex and/or catastrophic injuries, illnesses or diseases. They advocate for members who have medical and behavioral health conditions that require treatment by a variety of different specialists and ongoing or intermittent care.

Case managers coordinate services needed for home health and skilled nursing facilities in order to maximize contract benefits, improve patients' health and ability to function, and reduce the likelihood of complications. Case managers facilitate appropriate access to a variety of specialized health care providers. Cases are often ongoing due to the nature of chronic conditions. Case management ensures coordination of benefits and health services across the continuum of care for members with a variety of health care needs.

The goals of case management are to:

- Support and encourage individual accountability for health and wellness (self-care management)
- Promote the efficient use of health care benefits
- Improve member satisfaction with the health plan and health care system
- Maximize health and functional outcomes
- Help members coordinate services that meet their needs and navigate through the health care system

Disease Management
BlueCross offers disease management education to members with any of the following chronic conditions: hypertension, hyperlipidemia, coronary artery disease (CAD), diabetes, chronic obstructive pulmonary disease (COPD) and asthma.

BlueCross identifies members for this program through health risk assessments or claims data analysis. Physician referrals into the program are welcome. The program's goal is to assist members in managing their conditions through education. Participation in the disease management program is voluntary and available at no charge to the member.

For high-risk members, registered nurses will:

- Talk with members about their conditions
- Review their medications and current treatments
- Discuss best strategies, set goals and create action plans
- Help members understand their doctors' recommendations
- Connect members to other helpful programs, as needed
- Answer questions or address concerns

Some members who have any of the above diagnoses may be candidates for home monitoring of weight and blood pressure. BlueCross will contact providers to determine if this type of monitoring may benefit their patients.

Providers can refer their patients to Disease Management by contacting BlueCross at 800-327-3238. Or, if local in Columbia, SC, call 264-3100.

Quality Improvement

The BlueCross Medicare Advantage Quality Improvement (QI) program defines requirements for Medicare Advantage network providers, including, but not limited to, medical record keeping practices. The BlueCross Medicare Advantage QI program is customer-focused, data-driven and process-oriented. Some requirements may not apply to every facility.

The QI department and QI Committee initiates clinical, service and safety activities based on the health plan's performance data, such as:

- HEDIS and clinical indicators
- Clinical Practice Guideline monitoring
- Disease management conditions
- Quality of care reviews
- Continuity and coordination care
- Accessibility and availability reports
- Member satisfaction surveys
- Telephone responsiveness
- Grievance and appeals
- Timeliness of handling medical and pharmacy management requests
- Activities CMS requires

Collaborative Effort

Both BlueCross and Medicare Advantage network providers must support a successful quality improvement program. Advising, supporting and actively participating in the development and implementation of good processes and improvements are vital components of a successful QI program. BlueCross adheres to established QI standards, including, but not limited to, accessibility requirements, timeliness requirements and medical record keeping practices that providers can follow in pursuit of excellent care and service.

Accessibility Requirements

Providers shall provide or arrange for the provision of medical advice to members on a timely basis. Advice must be available 24 hours a day, seven days a week via a telephone response. Providers are not obligated to provide any health service not normally provided to others, or services for which they are not authorized by law to provide.

Timeliness Requirements

Category	Standard
Preventive Care Appointment or Immunization	Within eight weeks of a member's request
Routine Appointment	Within 14 days of a member's request
Urgent Appointment	Within 48 hours of a member's request
Emergency Care	Immediate
After-Hours Care	24 hours a day, seven days a week
Telephone Responsiveness	• During office hours, a physician or designee will assess the member according to patient care needs. • Providers should give a timely response to incoming phone calls. • Providers must answer calls in six rings or less. • Providers can only put members on hold two minutes or less.

Medical Record Keeping Practices

The patient medical record serves as legal documentation of services received and allows for evaluation of continuity and coordination of care. BlueCross requires providers to maintain timely and accurate medical, financial and administrative records related to services rendered to BlueCross Medicare Advantage members.

Minimum Requirements

- Maintain medical records for at least 10 years from the date of service unless a longer time period is required.
- Store medical records in a secure location using an efficient tracking process for ease of retrieval.
- Show either a patient name or ID on each page.
- Ensure medical records are dated, legible and signed.
- Maintain current problem lists.
- Prominently display allergies/adverse reactions**.**
- Prominently note current medications and dosage.
- Describe recommended immunizations and preventive health care.
- Include initials and date that the primary care physician received and reviewed a consultation report and labs/radiology results.
- Include a statement as to whether the member executed an advance directive.

Written Policies

Each provider must have policies and procedures as indicated here:

Policy Required	Recommended Risk Management
Advance Directives	• Make information available. • Document discussion in medical record. • Keep copies. • Notify hospital upon admission. • BlueCross network providers must document in a prominent place in medical record if individual has executed an advance directive [422.128(b) (1) (ii) (E)].
Communicable Disease Reporting	• Report communicable diseases as required by the State Health Department. • Report within one day. • Define reporting responsibilities. • Address completion and submission of forms.
Confidentiality and Security of Medical Records	• Have confidentiality policy for handling health information and medical records that meets state and federal requirements, including release of information. • Review the confidentiality policy and procedures with staff at least annually. • Ensure timely access for members to their records and information.
Foreign Language Translation and Services for the Hearing Impaired	• Provide assistance for both situations. • Make available an interpreter for phone calls and face-to-face interactions. • Notify member and his or her family that you provide an interpreter. • Identify resources.

Policy Required	Recommended Risk Management
Medical Emergency	• Have mechanism in place for responding. • Identify medical emergency code. • Identify who directs activities. • Identify who determines if you call 911.
Medication Management	• Have mechanism in place for procuring, storing, controlling and distributing medications. • Address narcotics, even if to note they are not kept on site. • Address recalls. • Address emergency and sample drugs. • Explain sign-out log. • Address prescription pad accessibility.
Communication	• Develop, implement and sustain an efficient communication protocol between primary care physician and medical specialists, including behavioral health specialists, to ensure effective coordination of care.

Section 7: Claims Submission

Claims Submission

This section provides information about claims submission, processing and payment. Providers should submit all claims for BlueCross Medicare Advantage members, except for certain services that must be billed to Original Medicare (e.g. certain clinical trial services CMS determines and hospice care). If a provider submits a claim to BlueCross but should have sent it to Original Medicare, BlueCross will return the claim to the provider for submission to the local carrier or fiscal intermediary.

General Information

Providers should always submit BlueCross Medicare Advantage claims electronically using Medicare billing guidelines and format (CMS-1500 or UB-04), and the National Provider Identifier (NPI). Note: Although not a fiscal intermediary or Part B Carrier, BlueCross processes claims for our Medicare Advantage members. Additional information is available from CMS at: http://www.cms.hhs.gov/Manuals/IOM/list.asp. Search for publication #100-04.

Providers should include the member's complete and accurate identification number when submitting a claim. The complete identification number includes the three-character alpha prefix

and subsequent numbers as they appear on the member's ID card. BlueCross cannot process claims with incorrect or missing alpha prefixes and member identification numbers. Claims submitted without all required information will be returned (paper submission) or denied (electronic submission).

To facilitate prompt payment, providers should transmit claims in the HIPAA 837 format using the appropriate payer code, C63 (for all plans).

When to Submit Claims

BlueCross encourages providers to submit all claims as soon as possible after the date of service to facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements. Exceptions may be made to the timely filing requirements of a claim when situations arise concerning other payer primary liability such as Original Medicare, Medicaid or third-party insurers, or legal action and/or an error by BlueCross.

BlueCross must submit encounter data and medical records to certify completeness and truthfulness of information submitted to CMS, [42 CFR 422.50(a) (8); CFR 422.50(1), (2) and (3)]. In turn, BlueCross Medicare Advantage network providers must submit completely and accurately coded claims, and assist BlueCross in correcting any identified errors or omissions.

Coding Claims

An important element in claims filing is the submission of current and accurate codes to reflect the provider's services. HIPAA-AS mandates the following code sets:

1. The Internal Classification of Disease – Ninth Revision – Clinical Modification (ICD-9-CM)
2. The Physician's Current Procedural Terminology, Fourth Edition (CPT)*
3. The Healthcare Common Procedure Coding System (HCPCS)

The following information identifies the purpose of each code set. BlueCross annually updates coding books that explain how to submit code sets.

*Current Procedural Terminology © 2005 American Medical Association. All Rights Reserved.

ICD-9-CM

To code diagnoses (Volumes 1 and 2) and hospital procedure codes on inpatient claims (Volume 3), use the International Classification of Diseases – Ninth Revision – Clinical Modification (ICD-9-CM) developed by the Commission on Professional and Hospital Activities. ICD-9-CM Codes in Volumes I and 2 appear as three-, four- or five-digit codes, depending on the specific disease or injury being described. Volume 3 hospital inpatient procedure codes appear as two-digit codes and require a third and/or fourth digit for coding specificity.

CPT

The Physician's Current Procedural Terminology, Fourth Edition (CPT) is a systematic listing of procedures and services practitioners perform. The American Medical Association (AMA) developed the CPT codes. Each procedure code or service has a five-digit code.

If a provider can not find a specific CPT code that accurately describes the service, he or she may submit an unlisted procedure code. Whenever a provider submits an unlisted procedure code, he or she must always include a complete written description of the service with the claim.

For electronic claim submission, the provider must include the service description in the 2400 Loop of the NTE segment.

HCPCS
The Healthcare Common Procedure Coding System (HCPCS) Level 2 identifies services and supplies. HCPCS Level 2 codes begin with letters A-V and providers use them to bill services such as home medical equipment, ambulance, orthotics and prosthetics, drug codes and injections.

Electronic Format
Filing claims electronically is the most effective way to submit claims for processing and receive payment.

The Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA-AS) passed by Congress in 1996 sets standards for the electronic transmission of health care data. Electronic submitters must submit claims using the ANSI 837x4010A1 format. The HIPAA-AS Implementation Guide provides comprehensive information providers need to create an ANSI 837 transaction. To download this guide from the Internet, go to: www.wpc-edi.com/hipaa/HIPAA_40.asp.

National Provider Identifier
Providers submitting claims electronically must include their 10-digit, unique National Provider Identifier (NPI) numbers. The NPI replaced all legacy provider identifiers (e.g., UPIN and BlueCross numbers) and identifies a health care provider in all standard transactions.

CMS-1500 Claim Form
On the next page is an example of the CMS 1500 claim form. After the form there is a chart that identifies the required fields a provider must complete in order for the claim to process correctly. The numbers to the left of the chart correspond to those on the claim form. If any of the "required" fields are left blank or are incomplete, BlueCross will return the claim (if paper) or deny it (if electronic).

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

DISCLAIMER: information referenced is based on current crosswalk availability and is subject to change

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

1 LOOP 2310A or 2420F – Line Level

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								2		NPI	
2										NPI	LOOP 2310B or LOOP 2420A – Line Level
3										NPI	
4										NPI	
5										NPI	
6										NPI	

3

25. FEDERAL TAX I.D. NUMBER SSN EIN
LOOP2010AA or LOOP 2010AB – Line level

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

4

LOOP2310D or LOOP 2420C
a. – Line level b.

33. BILLING PROVIDER INFO & PH # ( )

5

a. LOOP2010AA b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

1 Report the referring physician NPI number (2310A or 2420F; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)
2 Report NPI for rendering physician if applicable (2310B or 2420A; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)
3 After mandate use the nine-byte EIN only when filing to BlueCross BlueShield of South Carolina (2010AA or 2010AB)
4 Report NPI of facility/group where services were rendered (2310D or 2420C; Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)
5 Report NPI of facility/group where services were billed (2010AA : Enter 'XX' in the NM108 data element to indicate an NPI is present in NM109)

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

CMS-1500 Required Field Information		
Field No.	**Field Name**	**Explanation**
1a	Insured's ID Number	Enter the policyholder's alpha-prefix and ID number as shown on his or her identification card.
2	Patient's Name	Enter the patient's full "given" last and first name and middle initial.
3	Patient's Date of Birth	Enter the correct date of birth (MM/DD/YY) and sex of the patient.
4	Insured's Name	Enter the policyholder's last and first name and middle initial.
5	Patient's Address	Required if it is not the same as the policyholder's address.
6	Patient Relationship to Insured	Check the appropriate box. Do not use the box for "Other."
7	Insured's Address	Enter the complete address of the policyholder.
8	Patient Status	Check the appropriate box.
9	Other Insurance Information	Required if the answer to 11d is "yes." If the patient has other coverage, enter the name of the other insured.
9a	Other Insured's Policy or Group Number	Enter the other insured's policy or group number in this field.
9b	Other Insured's Date of Birth	Enter the other insured's date of birth and sex.
9c	Employer's Name or School Name	Enter the employer's or school's name.
9d	Insurance Plan	Enter the insurance plan name or program. Use block 9d to indicate that a Medicare-eligible patient elected not to purchase Medicare Part A and/or Part B coverage. Enter "No Medicare Part A and/or Part B Coverage," depending on the patient's situation.
10	Is Patient's Condition Related To	Check the appropriate box if the patient's condition is related to employment or an auto accident, or check "other."
11d	Another Health Benefit Plan	Request this information from the member. If the answer is "yes," go back and complete blocks 9-9d.
14	Date of Current Illness/Injury/Pregnancy	Enter the date (MM/DD/YY) for accident and medical emergency situations. If you submit services that relate to more than one accident or medical emergency, please submit separate claims for each situation.
17	Name of Referring Physician or Other Source	Enter the name of the referring physician for out-of-network services. For lab and X-ray claims, enter the physician's name who ordered the diagnostic services.
17B	ID Number of Rendering Physician	Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

CMS-1500 Required Field Information		
Field No.	**Field Name**	**Explanation**
21	Diagnosis or Nature of Illness/Injury	Enter an ICD-9-CM code with at least three digits of the code. List the primary diagnosis first. If there is more than one diagnosis, indicate in field 24E which diagnoses apply to the procedure you are billing for on each line item of the claim form. BlueCross will not accept narrative descriptions alone.
24A	Date of Service From/To	If you submit office or hospital outpatient services, submit each service and/or each date of service on a separate line with the same "From" and "To" dates. BlueCross allows date spanning on a line for a practitioner billing inpatient services within a month, a home medical equipment (HME) supplier billing for the monthly rental of equipment, or a home infusion therapy (HIT) provider. Inpatient charges may be submitted using a date span if: • The services provided within the date span are the same procedure code. • The dates of service are consecutive. • Services were provided within the same month. To bill HME rentals, submit the appropriate HCPCS (HCFA Common Procedure Coding System) code with an "-RR" modifier. List each month's rental on a separate line with one unit of service.
24B	Place of Service	Enter the place-of-service code using the two-digit codes found in the HCPCS manual. If the place-of-service code on the claim does not match the procedure code, or if you leave this field blank, BlueCross will return the claim.
24D	Procedure Codes/Modifiers	Enter the place-of-service code using the two-digit codes found in the HCPCS manual. If the place-of-service code on the claim does not match the procedure code, or if you leave this field blank, BlueCross will return the claim.
24F	Total Charge	Submit charge for each line.
24G	Days or Units	Enter the appropriate number of services (in whole numbers) based on the time period or amount the procedure code designates. You must enter at least one unit. To bill anesthesia, submit the actual time (in minutes) spent administering anesthesia services.
24J	Rendering Provider ID	Enter the rendering provider's NPI number in the lower unshaded portion. In the case of a service provided incident to the service of a physician or non-physician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower unshaded portion.

CMS-1500 Required Field Information		
Field No.	**Field Name**	**Explanation**
25	Federal Tax ID Number	Enter your practitioner/supplier federal taxpayer identification number (TIN). If you are a sole proprietor, your Social Security Number is your TIN. If you are an entity other than a sole proprietor, please submit your employer identification number (EIN). Note: If you do not give your federal tax number, or if the number you give is less than nine digits, BlueCross will return the claim to you.
26	Patient's Account No.	Required field for electronic submission.
27	Accept Assignment	Required for BlueCross Medicare Advantage claims.
28	Total Charges	Enter the total charges from 24F. The line items you submit must equal the Total Charge in field 28 or BlueCross will return the claim. If you submit a paper claim that has more than six line items, do not total the charge on the first claim form. Indicate "continued" in this field and attach additional claim forms until you have submitted all services. On the final claim form, submit the total charge.
31	Signature of Physician	Either the physician's signature, a computer-printed name, a stamped facsimile or the signature of an authorized person is acceptable. The signature identifies that the practitioner (or someone under the personal supervision of the practitioner) provided services reported on the claim.
32	Name and Address of Facility	Enter the name and address of the facility where the practitioner rendered services.
32A	Service Facility Location Information NPI	If required by Medicare claims processing policy, enter the NPI of the service facility.
33	Physician/Supplier's Billing Number and Address	Indicate the complete billing name and address of the practitioner/supplier. The practitioner's/supplier's billing number is also required in this area. If billing as a group, the group provider number is required.
33a	Billing Provider/Group NPI	Enter the NPI of the billing provider or group. This is a required field.

How to Submit a Late Charge on a CMS-1500

A late charge is a claim for additional services that is submitted after the original submission of a claim. To submit a late charge, send BlueCross a **new** claim showing **only** the additional services. Do not re-submit the original claim with the additional late charges.

How to Submit a Late Credit on a CMS-1500

When a provider determines that a claim was submitted in error, the provider should submit a copy of the original claim with corrected claim information (noting the changes) to correct the patient's records.

UB-04 Billing Guides

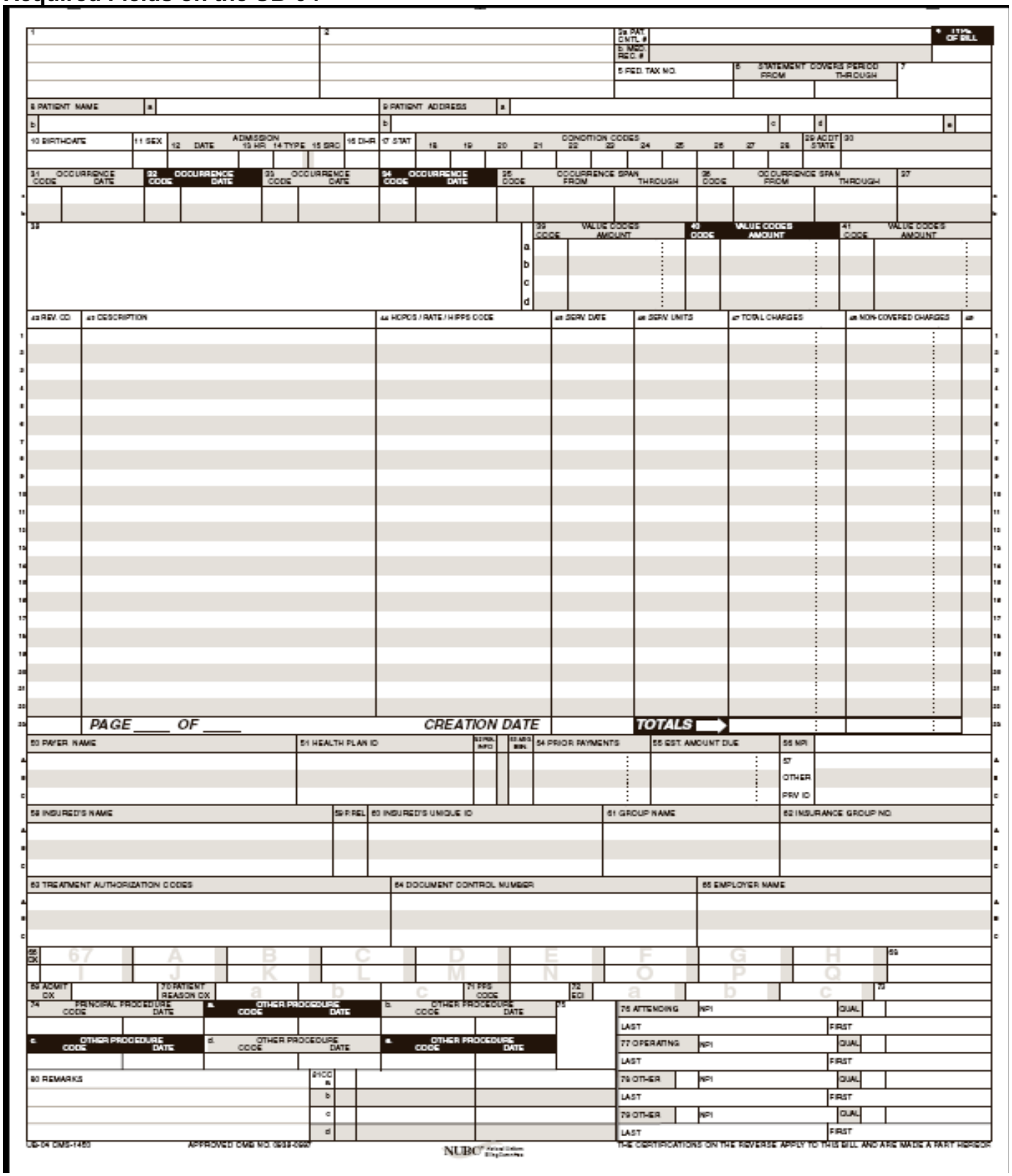
The National Uniform Billing Committee (NUBC) offers a UB-04 billing guide published by the American Hospital Association, called the *National Uniform Billing Guide*. To order a copy of the guide and updates, visit www.nubc.org/guide.html and select "Become a Subscriber."

Required Fields on the UB-04

The next page shows an example of the UB-04, followed by a chart that identifies the required fields that providers must complete for claims to process accurately. The numbers to the left of the chart correspond to the form locator (FL) field on the claim form. If one or more of the "required" fields are left blank or are incomplete, BlueCross will return the claim (if paper) or deny it (if electronic).

The UB-04 Required Field Information chart provides basic filing instructions providers need to submit services for payment.

Required Fields on the UB-04



Required Fields on the UB-04

UB-04 Required Field Information		
FL No.	**Form Locator (FL) Name**	**Explanation**
42	Revenue Code	This field allows for a four-digit revenue code that represents a specific accommodation, ancillary service or billing calculation. Revenue codes must be valid for the Type of Bill (FL4) indicated on the claim form.
43	Revenue Description	Complete this field with the standard description assigned each revenue code. You can find a list of revenue codes and their descriptions in the *National Uniform Billing Guide*.
44	HCPCS/Rates	Enter HCPCS codes if your provider contract requires them.
45	Service Date	Required on all outpatient claims when you give a date span in the Statement Covers Period (FL 6). You must provide a specific date for each service you bill on a line.
46	Service Units	This field identifies the number of services the patient received (e.g., the number of days in a particular accommodation) or the time required to provide at least one unit of service for each revenue code billed. For accommodations, the unit of service field must match the total number of days indicated in FL 6. Calculate each 24-hour period as one day. To calculate units, round up to the nearest whole number.
47	Total Charges	Submit a charge for each billed revenue code. If there is no charge, enter either 0.00 or N/C on the line item or BlueCross will return the claim.
50	Payer	Enter your local BlueCross BlueShield Plan name followed by the Plan Code.
51	Provider Number	Enter your facility's BlueCross provider billing number. The provider number you enter must correlate with the Type of Bill (FL 4) or BlueCross will return the claim.
56	NPI	Enter your facility's NPI number.
58	Insured's Name	Enter the last and first name of the policyholder, using a comma or space to separate the two. Do not leave a space between a prefix (e.g., MacBeth). Submit a space between hyphenated names (e.g., Smith Simmons) rather than a hyphen. If the name has as suffix (e.g., Jr., III), enter the last name followed by a space and then the suffix (Miller Jr., Roger).
59	Patient Relationship	Enter a code that indicates the relationship of the patient to the policyholder. Refer to the *UB-04 Data Element Manual* for a complete list of appropriate codes you should use to complete this field.
60	Insured's Unique ID	Enter the alpha prefix and identification (ID) number as it appears on the patient's ID card.

UB-04 Required Field Information		
FL No.	**Form Locator (FL) Name**	**Explanation**
67	Principal Diagnosis Code/Other Diagnoses	Submit a valid principal ICD-9-CM diagnosis, including the fourth and fifth digits when appropriate.
69	Admitting Diagnosis Code	Enter the ICD-9-CM diagnosis code for the patient at the time of admission.
74	Principal Procedure Code	Inpatient Services: An ICD-9-CM Volume 3 procedure code and the date the practitioner performed the procedure are required in this field when you bill revenue codes 036X, 049X and 075X.
76	Attending Physician/ID-Qualifier 1G	Enter the Unique Physician Identification Number (UPIN) and the name of the licensed physician who BlueCross normally expects to certify and recertify the medical necessity of the services the patient received and/or who has primary responsibility for the patient's medical care and treatment during an inpatient stay.

Common Claims Filing Errors

Proper payment of Medicare Advantage claims is a result of efforts of the provider, employee clinicians and billing personnel, and of adherence to national and local payment policy requirements. This section: (a) describes common claim filing errors that can result in claim rejections or claim denials, (b) includes general requirements for properly resubmitting rejected claims, and (c) discusses the process for appealing a denied claim.

Generally, there are three common types of errors that result in claim denials:

- Billing/data entry errors
- Noncompliance with coverage policy
- Billing for services that are not medically necessary

In some cases, additional documentation may be required in order for the claim to complete adjudication. After BlueCross receives the additional information, the claim is adjusted or corrected.

Billing/Claim Filing Error

A common billing or data entry error involves omission of required data (either on the CMS-1500 claim form or the electronic claim record). An example is entering improper bill types. This includes submitting the claim without a discharge bill type (FL/Block 4) when the status code (FL/Block 22) indicates that the patient was still in the facility.

These claim errors can result in claim rejections or denials:

- Incorrect member alpha-prefix and/or ID number
- Invalid/missing diagnosis code
- Past timely filing requirements
- Incorrect provider number
- Missing, incorrect or invalid modifier
- Invalid/missing Healthcare Common Procedure Coding Systems (HCPCS) code
- Missing or incorrect quantity

Compliance Issues Resulting in Claim Denials

BlueCross may deny coverage or reject a claim for these reasons:

- The patient is not eligible for Medicare Advantage benefits.
- The provider is not qualified to furnish the Medicare services billed.
- Medicare Advantage is the secondary payer to other insurance and the primary plan has not processed the claim.
- Services are excluded by national or local coverage policy because:
    - The service is not covered.
    - A limited benefit is exhausted.

- Claim/services do not meet technical requirements for payment, e.g., non-compliance with Correct Coding Initiative (CCI) edits (including national and local requirements).

Eliminating Procedure Code Unbundling

Unbundling occurs when a provider bills in multiple parts for a procedure that would typically be reported under a single comprehensive code. This unethical act reflects improper procedure reporting under CCI coding requirements. CMS has identified specific code pairs that BlueCross will reject if a provider bills for them for the same patient on the same day. In most unbundling cases, providers can not bill beneficiaries for amounts Medicare denies due to unbundling.

When the Patient is Not Entitled to Medicare Benefits
Determine a patient's Medicare eligibility before providing services in order to help prevent a claim denial or claim rejection because the patient is not entitled to Medicare coverage. Determine eligibility by getting a copy of the member's health insurance card during the first visit or facility admission, and by confirming eligibility to receive benefits for the services to be provided.

When the Provider is Not Qualified to Furnish the Services Billed
A provider's billing office must be aware of the status of not only its billing provider number, but also whether all physicians and clinicians furnishing and billing for Medicare-covered services through the provider PIN are legally permitted to participate in the Medicare Program. BlueCross may not pay for services furnished by excluded providers. In addition, BlueCross may prohibit facilities from submitting claims in some situations for services they furnished if an excluded employee was indirectly involved in the care of a Medicare Advantage member (e.g., an excluded Medical Director). Providers need to ensure that they do not bill BlueCross for services furnished by individuals excluded from Medicare participation.

Special Considerations When Submitting BlueCross Medicare Advantage Claims
Depending on the specialty of the provider, there are additional, special considerations a biller must be aware of when submitting claims. These considerations include:

- Determining whether claims should be submitted to Medicare
- Providing Advance Member Notices (ABNs)
- Providing Notice of Exclusions of Medical Benefits (NEMBs)

Section 8: Payment Methodology

In general, BlueCross pays claims per Medicare reimbursement methodology, less any applicable member cost sharing amount, which the provider can collect from the member.

Each provider contract, amendment or payment exhibit describes specific details regarding contracted payment amounts.

CMS applies a risk-adjusted payment methodology based on diagnostic and demographic information. BlueCross conducts ICD-9 coding validation reviews of all claims submitted by network physicians. These reviews help BlueCross comply with CMS regulations and assist network physicians in achieving maximum reimbursement.

This table shows the payment process and payment responsibility.

Step	Who Does It	What Happens
1	Provider	Submits claims to the local BlueCross and/or BlueShield Plan.
2	BlueCross	Pays benefits directly to the network provider.
3	Provider	Bills members only the member's cost share (coinsurance, copayments and/or deductible) amount up to the allowable fees the plan has established. Providers can collect the cost share amount when they provide services.
4	Member	Pays the cost share (coinsurance, copayment and/or deductible) amount as stated in the contract up to the allowable fees the plan has established.

As a Medicare Contractor, BlueCross must ensure that it pays only for those services that comply with Medicare coverage and coding rules, including only reasonable and medically necessary services. For medically necessary services, BlueCross, as a Medicare contractor, must ensure that services are rendered in the most cost-effective manner (i.e., consideration is given to the location of service and the complexity and level of care provided).

To ensure that payment is made only according to Medicare rules, BlueCross performs data analysis to identify potentially aberrant patterns of care and to apply the Medical Review process.

How Does Policy Development Apply to Medical Review (MR)?
Medicare Contractors conduct the MR process in accordance with both national and local policies that are the foundation of the review process. The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Contractors apply Medicare policies from regulations, National Coverage Decisions (NCDs), coverage provisions in interpretive manuals and local coverage determinations (LCDs) to comply with the Social Security Act.

National Coverage Determinations (NCDs)
CMS developed NCDs to describe the circumstances for Medicare coverage for a specific medical service, procedure or device. NCDs generally stipulate conditions under which a service is covered (or not covered) under Title XVIII, Section 1862(a) (1) of the Social Security Act or its applicable provisions. CMS typically issues these policies as CMS program instructions. Once published in a CMS program instruction, an NCD is binding on all Medicare Contractors and providers. NCDs that CMS made under Title XVIII, Section 1862(a) (1) of the Social Security Act are also binding for Administrative Law Judges (ALJs) during the claim appeal process.

Current NCD Information
A list of the most current NCDs is available at http://www.cms.hhs.gov/center/coverage.asp on the CMS website.
The Medicare National Coverage Determinations Manual is available at http://www.cms.hhs.gov/Manuals/IOM/list.asp on the CMS website. Search for publication #100-03.

Coverage Provisions in Interpretive Manuals
Coverage provisions in interpretive manuals include instructions CMS publishes that are not NCDs. CMS uses these instructions to further define when Medicare may cover or not cover services. Once published, the coverage provision in an interpretive manual is binding for all Medicare Contractors and providers.

Local Coverage Determinations (LCDs)
Section 522 of the Benefits Improvement and Protection Act (BIPA) created the LCD. An LCD is a decision by a Medicare Contractor to cover a particular service on a contractor-wide basis in accordance with Title XVIII, Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). CMS published the Final Rule establishing LCDs on November 11, 2003.

Local Medical Review Policy (LMRP) to LCD Conversion
Effective December 7, 2003, Medicare Contractors began issuing LCDs instead of LMRPs. Fiscal Intermediaries (FIs) and Carriers retired or converted all existing LMRPs into LCDs by December 2005.

LCDs include codes that describe services Medicare does and does not cover, for example: (a) lists of Healthcare Common Procedure Coding System (HCPCS) codes that identify services to which a LCD applies; (b) lists of International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) codes for Medicare-covered services; and (c) lists of ICD-9-CM codes for services Medicare considers not reasonable and necessary. As a Medicare Contractor, BlueCross considers these coding descriptions only if they are integral to determination of medical necessity. LCDs specify under what clinical circumstances a service is reasonable and necessary, and serve as administrative and educational tools to assist providers with correctly submitting claims.

CMS publishes LCDs to provide local guidance to the public and medical communities within their jurisdiction. BlueCross develops LCDs by considering medical literature, the advice of local

medical societies and medical consultants, public comments and comments from the provider community. BlueCross may develop LCDs individually or collaboratively with other contractors. BlueCross ensures that all LCDs are consistent with all statutes, rulings, regulations and national coverage, payment and coding policies.

LCDs do not provide guidance to address fraud. For example, the following sentence would be inappropriate in an LCD: “If, on post pay review, we find that the provider billed XYZ procedure to Medicare after the effective date of this LCD, we will consider that billing fraudulent.” This sentence would be an acceptable LCD if the Contractor replaced the word “fraudulent” with the phrase “not reasonable and necessary.”

BlueCross continually reviews medical payment policies to determine how local practices align with national coding and billing guidelines by the American Medical Association’s (AMA’s) Current Procedural Terminology (CPT), the Centers for Medicare and Medicaid Services (CMS) and specialty societies. BlueCross follows National Coverage Decisions (NCDs) to determine the conditions under which a service is or is not covered.

What Documentation Do Providers Need To Submit With Medical Review (MR)?
Providers should document and maintain legible and comprehensive medical records. The medical record chronologically documents the patient’s medical history in sufficient detail, and substantiates services as medically necessary.

Providers should document in the patient’s medical record precise descriptions of all aspects of patient care, including information regarding the need for and results of services provided. Dictated and transcribed descriptions and other related medical information must be legible and accurate. While initial descriptions of services provided may not be altered, providers may submit documentation in addition to that initially submitted to support a claim.

Network providers are responsible for voluntary disclosure of information that was omitted or incorrect in the initial claim submission. If submission of incorrect claim information results in an overpayment, the provider agrees to promptly return the overpaid amount to BlueCross.

BlueCross requests documentation through the Additional Documentation Request (ADR) letter. Examples of MR documentation BlueCross needs may include, but are not limited to:

- Medical records, including progress notes, a current history and physical, and a treatment plan
- Documentation of the identity and professional status of the clinician
- Laboratory and radiology reports
- A comprehensive problem list
- A current list of prescribed medications
- Progress notes for each visit that demonstrate the patient’s response to prescribed treatment
- Documentation supporting the time spent with the patient when using time-based codes
- Any required referrals or prescriptions (for many non-physician services/supplies)
- Any required contractor certifications

Payment by Provider Type for BlueCross Medicare Advantage Covered Services

Provider Type/Claim Form	Payment Methodology
PPS Acute Care Hospital or Indian Health Service Facility (IHS) UB-04	Payment for inpatient services is based on the Prospective Payment System (PPS) using diagnosis-related group (DRG) methodology. Payment includes applicable capital, disproportionate share hospital (DSH) and/or capital indirect medical expense (IME) payments. Payment does **not** include any operation IME costs, graduate medical education (GME), or nursing/allied education reimbursement expenses. Reimbursements for these expenses may be requested from the Original Medicare Fiscal Intermediary by submitting a shadow bill for the rendered services. The Fiscal Intermediary accumulates requests for reimbursement and determines reimbursements at a function of Medicare Cost Report settlement. Bad debt (beneficiary deductible, coinsurance and copayment amounts) is not reimbursable. Payment for inpatient transfers is determined per Medicare guidelines. Payment to a transferring hospital is calculated as a per diem rate based on length of stay. Payment for swing beds is made per Skilled Nursing Facility (SNF) contractual reimbursement. Payment for outpatient services is based on Medicare Ambulatory Patient Contingency (including Medicare coinsurance) or fee schedule if excluded from Outpatient Prospective Payment System. Payments for inpatient and outpatient outliers are determined per Medicare guidelines. Payment for organ acquisition is determined according to billing requirements of the local BlueCross BlueShield Plan. The facility should bill the specific organ acquisition fee based on the most recent finalized CMS cost reports.
Acute Long Term Care Hospital UB-04	Five-year transition to a prospectively paid system for inpatient services ended October 1, 2007. Facilities have the option to transition immediately to 100 percent PPS reimbursement. Payment is based on the Medicare payment methodology chosen by the provider. Short stay and high cost outliers apply.
Ambulance UB-04 (hospital bed) CMS-1500 (freestanding)	Payment based on Medicare ambulance fee schedule.
Ambulatory Surgical Center (ACS) UB-04	Payment based on the ASC fee schedule

Anesthesia UB-04 or CMS-1500 (as applicable)	Physician payment is based on Medicare methodology (Medicare anesthesia conversion factor by locality x sum of code designated base units + time units). Payment for Physician Medical Direction of two or more Nurse Anesthetists concurrently is 50 percent of the allowance for the service the physician performs. BlueCross applies CMS billing protocol for these: • Time Units in 15-minute increments. Payment is prorated for less than 15-minute increments per CMS guidelines. • Base Units according to CPT-accepted American Society of Anesthesiologist (ASA) codes. • Physical status modifiers (complexity of anesthesia service the physician provides): no additional reimbursement for submission of service billing modifiers, e.g. P1-P6. • Qualifying circumstances (submission of risk codes): no additional reimbursement, e.g. 99100, 99116, 99135, 99140.
Clinical Trials UB-04 or CMS 1500	Services associated with clinical trials are generally not payable under Medicare Advantage plans. Providers should not submit these claims to BlueCross.
Community Mental Health Centers (CMHC) UB-04 (facility services, if applicable) CMS-1500 (clinic services)	Separate payment for CMHC services provided by Medicare-eligible mental health practitioners based on the Medicare Fee Schedule or a negotiated local BlueCross and BlueShield Plan-specific amount. Payment for CMHC outpatient facility services is determined according to Medicare APC methodology (including Medicare coinsurance).
Clinic/Office- Administered Drugs CMS-1500	Payable under Medicare methodology. Payment allowance limits for Medicare Part B drugs and biologicals are at the Original Medicare Average Sales Price (ASP) rate with a few exceptions. The payment allowance limits: • For blood and blood products are 95 percent of the average wholesale price (AWP) • For infusion drugs furnished through covered durable medical equipment are 95 percent of the AWP regardless of whether or not the DME is implanted • For influenza, pneumococcal and hepatitis B vaccines are 95 percent of the AWP • For drugs, other than new drugs, not included in the ASP Pricing File or Not Otherwise Classified (NOC) Pricing File is 100 percent of the published wholesale acquisition cost (WAC) for the lesser of the lowest brand or median generic. If a payment limit is available from CMS, those limits will apply. Payment allowance limits for new drugs and biologicals not included in the ASP Medicare Part B Drug Pricing File or NOC Pricing File is based on 10 percent of the WAC.

Durable Medical Equipment (DME), Prosthetics, Orthotics, Medical Supplies CMS-1500	Payment is determined by one of these three CMS Medicare Durable Medical Equipment Prosthetics, Orthotic and Supplies (DMEPOS) payment methodologies: Fee Schedule – applies to the allowed amount for expendable supplies defined as those items that require frequent and substantial servicing, other prosthetic and orthotic devices, capped rental items, oxygen and oxygen supplies, and parenteral and enteral nutrition (PEN). Reasonable charge – applies to the allowed amount for certain dialysis equipment and supplies and to therapeutic shoes. Average wholesale pricing (AWP) – applies to the allowed amount for immunotherapy, bronchodilator and other DMEPOS drugs. Note: The beneficiary's permanent address, rather than the location of the DMEPOS supplier, determines the amount Medicare allows for a supplier service on mail-order services.
ESRD Facility (both independent and provider-based) UB-04	Payment is based on the Medicare composite rate as defined by Medicare methodology or on an amount established by a local BlueCross and BlueShield Plan. Payment for non-routine services (not included in the composite rate) is based on a fee schedule. BlueCross pays non-routine drugs according to the drug methodology above.
Federally Qualified Health Center (FQHC) Rural Health Clinic (RHC) (both independent and provider-based) UB-04	Payment if based on the lesser of the Medicare "all inclusive" rate or the national per-visit limit for FQHC (urban rural) or RHC facility type. FQHCs and RHCs agree to provide BlueCross with a copy of their most recent intermediary rate letters in order to establish a rate prior to the submission of claims. To ensure ongoing, appropriate and current payment, BlueCross encourages FQHCs and RHCs to provide a copy of their intermediary rate letters to their local BlueCross and BlueShield Plans each time the Fiscal Intermediary adjusts the rate.

Home Health Agencies UB-04	Payment is based on Medicare PPS home health resource group (HHRC) payment methodology and CMS' OASIS patient assessment software. Payment for covered services follows the standard CMS episode-based reimbursement methodology, including application of all standard Medicare billing protocols and claim elements for claim assessment. Follow CMS' billing protocol for submitting an initial notification claim when the episode treatment plan begins, and for submitting final claims at the end of the treatment episode. Prorated payment follows the standard Medicare plan process: 1. Initial payment occurs at the commencement (initial date of service) of the plan of care. 2. Payment of the balance for the episode follows the termination of a fully completed treatment episode. 3. Determination of a prorated payment for a fully completed episode follows the standard Medicare plan methodology of 60 percent of the episode payment upon the initial claim and the remaining 40 percent at the episode completion. 4. To determine payment for low utilization treatment plans (typically four visits or less) or for materially modified treatment plans which do not require or permit the full episode of treatment, BlueCross applies a prorated reimbursement per day of care based on standard Medicare payment methodology. Home health agencies should submit separate claims for their nursing services and applicable DME/medical supplies. Submitting these services on the same UB claim will result in rejection of the claim. Covered services not included in per visit rates under the DMEPOS fee schedule are eligible for payment.
Home Infusion UB-04 or CMS-1500	Payment for covered services is limited to Medicare-eligible services and requires Medicare-compliant billing. Submit claims for nursing services on UB format and claims for DME/supplies/drugs on a CMS-1500. Home health agencies may not bill their nursing services and applicable DME/medical supplies on the same UB-04 claim. Eligible home infusion providers should follow the protocol for home health billing as applicable.
Hospice	Direct all claims for hospice services to Original Medicare.
Clinic-based or Independent Laboratory and Radiology/Imaging Services UB-04 or CMS-1500	Payment is based on the Medicare Fee Schedule. Payment is allowed for covered lab services when billed by either the independent laboratory or the clinic/physician, except when services are eligible for Medicare reimbursement only when submitted by an independent laboratory. Payment for lab work performed at a Critical Access Hospital is allowed when billed within the inpatient and/or outpatient hospital per CAH methodology above.

Physician Services CMS-1500	Payment for physician services is based on the Medicare Fee Schedule and may include a site of service differential for physician services. Payment for additional reimbursement may apply to physicians who practice in a Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA).
Chiropractors (for Medicare-covered services) CMS-1500	Payment is based on the Medicare Fee Schedule. Per Medicare, chiropractor services are not eligible for payment under HPSA or PSA rules.
Other (Non-Physician) Health Care Professionals CMS-1500	Payment is based on the Medicare Fee Schedule (MFS) applicable for physicians. <u>85% of MFS</u> Advanced Nurse Practitioners Physician Assistants Clinical Nurse Specialists Registered Dieticians Medical Nutrition Therapists <u>100% MFS</u> Clinical Psychologist Physical Therapists Occupational Therapist Speech Therapist <u>75% of MFS</u> Clinical Social Worker
Psychiatric Hospital or CMS-Designated Mental Health Unit of an Acute Care Hospital UB-04	Payment for inpatient services is based on the Inpatient Psychiatric Facility (IDF) Prospective Payment System (PPS) using psychiatric DRGs.
Acute Care Hospital UB-04	Payment for outpatient services is based on Medicare APC or fee schedule if excluded from OPPS.

Section 9: Provider Appeals

Please refer to your provider contract or terms and conditions for provider appeal rights.