Introduction
Medicare BlueSM and Medicare BlueSM 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 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).

Purpose of This Guide
This manual serves as a reference for providers participating in the BlueCross Medicare Advantage Network.
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Chapter One: Provider Role and Responsibilities

Section 1: Professional Agreement

Each provider’s professional agreement lists the contractual responsibilities of both BlueCross and that network provider. Here is a general summary of the Professional Agreement:

- The provider will file all claims for Medicare Advantage members to the plan.
- BlueCross will reimburse the provider for covered services based on the member’s contract and Original Medicare allowance.
- The provider will accept BlueCross’ payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The preferred provider will not bill the patient for more than his or her applicable patient liability amount not to exceed the fee allowance.
- The provider agrees to cooperate fully with the Utilization Review Procedures in the Professional Agreement.
- The provider will use other network providers for a member’s care unless medically necessary services, supplies or equipment are not available from a network provider, or in cases of medical emergencies or urgently needed services.
- The provider agrees to bill promptly and in a manner approved by BlueCross for all services. Electronic Claims Submission (EMC) in the 837I or 837P HIPAA-compliant format is the required method of filing unless the provider has an exemption from Original Medicare (IOM 100-04, Chapter 24, Sections 90-90.6).

Unless otherwise prohibited by federal or state laws and regulations, BlueCross Medicare Advantage network providers agree to refer members to other BlueCross Medicare Advantage Preferred Provider Organization (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 may apply even if the member has a referral from a network provider. To find a BlueCross Medicare Advantage network provider, visit www.SouthCarolinaBlues.com and choose Find a Provider.

Section 2: 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’ responsibilities.

Section 3: Provider Credentialing

BlueCross Medicare Advantage cannot employ or contract with individuals excluded from participation in Original Medicare. All health care providers who submit bills to our Medicare Advantage Plan for reimbursement, both in and/or out of network, must be Medicare-certified providers [42 CFR 422.204(b)(3)]. Providers must have a Medicare provider number for the type of service rendered.

BlueCross Medicare Advantage verifies each provider’s Medicare status during credentialing and recredentialing processes, and periodically outside of the credentialing cycle. Credentialing is required for all practitioners who provide services to our Medicare Advantage members, including providers of physician groups and all other health care professionals who are permitted to practice independently under state law.

Potential network applicants receive the South Carolina Uniform Credentialing Application (SCUCA), specific network contracts and professional agreements for network participation. The SCUCA is available in the Providers area of the website. Choose Forms, Credentialing/Provider Updates and Credentialing. For contract or professional agreements, email provider.cert@bcbssc.com with your name, mailing address and the specific network contracts you need.

To apply for network participation, you must complete the application, attach the required documentation and submit the entire package to BlueCross. We will notify you of any missing or incomplete information. The average processing time for credentialing is 90 business days from when we receive a completed package. Any missing or incomplete information will delay the credentialing process.

You must submit this required documentation with your application:

- State license(s)
- Current DEA certificate
- Proof of malpractice coverage, including supplemental coverage
- Board specialists certificate, if applicable
- Electronic Claims Filing Requirement form (page 10 of the SCUCA application)
- NPI NPPES confirmation letter or email
• Appropriate IRS documentation (Letter 147C, CP 575 E or tax coupon 8109-C)
• A signed contract signature page for each network to which you wish to apply

Note: You only need to submit one SCUCA application, regardless of the number of networks for which you are applying.

BlueCross Medicare Advantage is not required to credential health care professionals who are permitted to furnish services only under the direct supervision of another practitioner, or hospital-based health care professionals who provide services to members “incident to” hospital services. (IOM 100-16, Chapter 6, Section 60.3)

Please email your completed application and documentation to provider.cert@bcbssc.com or fax to 803-264-4795.

Section 3.1: Provider Credentialing – Mental Health Network

Credentialing for mental health practitioners is coordinated through Companion Benefit Alternatives, Inc. (CBA) and covers the BlueCross Medicare Advantage plan. CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross. Recredentialing for all contracted providers occurs every three years. Our credentialing staff will contact you when it is time for you to recredential.

CBA has an established behavioral health network that includes credentialed mental health and substance abuse providers. To be considered eligible for the CBA network, you must be licensed by the appropriate South Carolina state licensing board to practice independently without supervision. Any licensed provider with a qualifier “intern” is not eligible to join our network.

There is an open network of behavioral health specialties that do not require credentialing for BlueCross Medicare Advantage:

• Addictionologists
• Behavioral health pediatricians specializing in childhood behavioral health disorders
• Certified psychiatric clinical nurse specialists
• Licensed clinical psychologists
• Licensed independent social workers – clinical practice
• Licensed marriage and family therapists
• Licensed professional counselors
• Psychiatric nurse practitioners
• Qualified psychiatrists
CBA requires you to do these things as part of the credentialing process:

1. Read, complete, sign and return the CBA Provider Credentialing Application.
2. Read, sign and return the CBA Professional Agreement (Please contact CBA at 800-868-1032, ext. 25744 to request a copy of this document).
3. Sign and return each HMO Hold Harmless Agreement (Appendix C of the CBA Professional Agreement).
4. Enclose a copy of the S.C. State License(s).
5. Enclose a copy of the DEA License (if applicable).
6. Enclose a copy of the protocol (nurse practitioners only).
7. Enclose proof of current malpractice coverage.

Please make sure you include all information when submitting your application. CBA cannot process applications until it receives all information. Please keep a copy of all application materials for your records.

Mail or fax the completed application and supporting documentation to:

Companion Benefit Alternatives, Inc.
ATTN: Network Coordinator, AX-315
P.O. Box 100185
Columbia, SC 29202
Fax: (803) 714-6456

Section 3.2: Provider Recredentialing

BlueCross requires recredentialing every three years for Medicare Advantage network providers. Our credentialing staff will contact you when it is time for your recredentialing.

We mail credentialing packages to health care practices. You must return the packages to us within the allotted time or you could lose your network participation. The re-credentialing package includes:

- BlueCross Credentialing Update forms for each practitioner in the practice. When submitting, include these for each practitioner:
  - State license(s)
  - Current DEA certificate, if applicable
  - Proof of malpractice coverage, including supplemental coverage
  - Board specialist certificate, if applicable
  - One practice information update form

Please email Credentialing Update forms and requested documentation to provider.cert@bcbssc.com or fax to 803-264-4795.
Section 4: 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 you choose to terminate participation with BlueCross Medicare Advantage, you must follow contractual termination provisions. The Centers for Medicare and Medicaid Services (CMS) requires providers to give at least 60 days’ notice to BlueCross when terminating participation without cause. We will notify all affected members of the termination of a provider contract within 30 days of receiving notice of termination. We will notify you in writing of reasons for any suspension or termination from network participation.

If you have any questions about contracting, please submit a Contract Request Form from the Provider page on our website www.SouthCarolinaBlues.com.

Section 5: Member Discrimination Prohibited

Discrimination against BlueCross Medicare Advantage members based on health status is prohibited [42 CFR 422.110(a)]. We cannot deny or limit condition of 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 End Stage Renal Disease (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

We cannot enroll any individual in a BlueCross Medicare Advantage plan that has been diagnosed with ESRD. Members who develop ESRD after enrolling can 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) (I)]. BlueCross and Medicare Advantage network providers cannot 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.

Section 6: Member Protections

Federal regulations establish protections for Medicare Advantage members. You cannot 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 cannot 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’ 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/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

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/Medicare/Medicare-General-Information/BNI/FFSEDNotices.html.

BlueCross Medicare Advantage members can 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.
Chapter Two: Member Rights & Responsibilities

Section 1: 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 can make plan elections and the limits on the number of elections they can make each year.

Medicare beneficiaries can 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.

Section 2: Disenrollment
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.

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

Section 3: Provider Advice & Advocacy
BlueCross cannot 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 can 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.

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

Section 4: Protecting Members’ Health 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, you should remove or cover other patient information on a payment register that contains information not related to the inquiry.

We 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 us in accurately documenting each inquiry.
Chapter Three: Medicare Advantage Plans

Section 1: Types of Medicare Advantage Plans

BlueCross offers two individual Medicare Advantage plans to Medicare-eligible recipients in South Carolina. We also serve as administrator for two employer-sponsored plans. All four plans are preferred provider organization (PPO) plans. You should confirm the level of coverage for all Medicare Advantage members before providing services. Level of benefits and coverage rules may vary.

Individual Plans

1. Medicare Blue
2. Medicare Blue Saver

Employer-Only Group Waiver Plans (EGWP)

1. Richland County Retirees
2. Spartanburg County Retirees

Section 1.1: Medicare Blue

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.

Sample Medicare Blue ID Card
Section 1.2: 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

Section 1.3: Richland County Retirees
Richland County Medicare Blue is a Medicare Advantage PPO plan that combines the benefits of traditional Medicare with Medicare Part D prescription drug coverage. It is an EGWP that administers administrative service only for Richland County retirees. 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 1.4: Spartanburg County Retirees
Spartanburg County Medicare Blue is a Medicare Advantage PPO plan that combines the benefits of traditional Medicare with Medicare Part D prescription drug coverage. It is an EGWP that offers administers administrative service only for Spartanburg County retirees. 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 2: How to Identify Medicare Advantage Plan Members
- The alpha prefix is ZCT.
- The member’s personal identification number follows the alpha prefix. The ID number sequence must be included with each claim submission.
- The suitcase on the front of the card, lower right, indicates the network.
- The plan name (Medicare Blue, Medicare Blue Saver, Richland County Medicare Blue, Spartanburg County Medicare Blue) is located on the front of the card in the upper right quadrant.

Members should always show their BlueCross ID card, not their Medicare card. 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, you may experience a delay in claim processing.

An ID card does not guarantee coverage. You can verify benefits and eligibility by using My
Insurance Manager<sup>SM</sup>, the Voice Response Unit (VRU) or by submitting a HIPAA-compliant
electronic transaction request.

**Section 3: General Coverage Information**

CMS has established requirements applicable to BlueCross Medicare Advantage benefit plans.
Find details on specific benefits and cost sharing included in each Medicare Advantage plan by

All BlueCross Medicare Advantage benefit plans offer benefits that:

- Provide beneficiaries with all Part A (except hospice care) and Part B services under
  Original Medicare if the beneficiary is entitled to benefits under both parts, and Part B
  services if the beneficiary is a grandfathered “Part B only” enrollee (CMS Internet-Only
  Manual (IOM) 100-16, Chapter 4, Section 10.2).

- Cannot impose limitations, waiting periods or exclusions from coverage due to pre-
  existing conditions that are not present in Original Medicare (IOM 100-16, Chapter 4,
  Section 10.2).

- Cover ambulance services dispatched through 911 or a local equivalent for which other
  means of transportation would endanger the member’s health (IOM 100-16, Chapter 4,
  Section 20.1).

- Offer all Medicare preventive services performed at a network provider without copay. A
  copay will apply, however, if a beneficiary is being treated or monitored for an existing
  medical condition during the preventive visit.

- Provide 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.

- Cover renal dialysis services for members temporarily outside of the plan’s service area
  [422.100(b) (1) (iii)].

- Offer a network of providers that allows sufficient access to covered services, according
to CMS standards [422.112(a) (1)].

- Provide benefits in a manner consistent with professionally recognized standards of
  health care [422.504(a) (3) (iii)].

- Make covered services available to members through office hours or telephone service,
  24 hours a day, seven days a week [422.122(a)(8)].
• 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: 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:

1. Case management.
2. Disease management.
3. A discharge coordination program.

Objectives of the programs are to:

a. Promote efficient use of health care resources.

b. Define and agree upon appropriate standards of care.

c. Ensure members receive appropriate care and follow-up hospital discharge.

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 of service.

We recommend that you verify coverage, benefits, contract eligibility and limitations for all patients prior to providing services.

We do not require prior authorization and/or admission review for the services to be covered. You remain financially liable, however, for services you provided that we later determine are not medically necessary and/or investigational.

**Section 4.1: Case Management**

Licensed health care professionals (registered nurses and 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 conditions.

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 they need and navigate through the health care system.

Section 4.2: Disease Management

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

We identify 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 members’ 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 these diagnoses may be candidates for home monitoring of weight and blood pressure. We will contact you to determine if this type of monitoring may benefit your patients.

Section 4.3: Discharge Coordination Program

BlueCross requires authorizations and continued stay reviews on all Medicare Advantage inpatient admissions. This service ensures members receive appropriate care and follow-up
when hospitalized as well as identifies those beneficiaries who may need more case management upon discharge.

Our team of registered nurses coordinates with hospital staff on discharge coordination and transitional services to:

- Facilitate referrals to network providers, internal case managers and disease managers as necessary.
- Facilitate smooth transitions home by working with hospital case managers and discharge planners to ensure a plan of care is in place.
- Have an after-care conversation with members.
- Address any gaps in care as soon as possible.

Section 5: 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:

- Healthcare Effectiveness Data Information Set (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.
Section 5.1: Medicare Advantage and CMS Star Ratings

CMS uses the five-star rating system to monitor plans to ensure they meet Medicare’s standards for quality of care and customer service. The overall plan rating gives a single summary score that makes it easy for members to compare plans based on quality and performance. Providers and health plans are rated but only health plans’ scores are publicly reported.

Current star ratings criteria are based on categories of member satisfaction, customer responsiveness and service, and quality of care. Medicare uses information from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Health Outcomes Survey (HOS), HEDIS measures and health care providers to give overall performance star ratings to Medicare health plans.

Providers can help improve our plan performance in these ways:

- Document all care in the patient’s medical record.
- Calculate and include body mass index (BMI) when documenting patients’ heights and weights.
- Code claims completely.
- Encourage medication adherence and medication management participation.
- Find formulary alternatives or complete coverage determinations.
- Respond to our requests for medical records timely (within five business days).

Section 6: 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. You are not obligated to provide any health service not normally provided to others, or services for which you are not authorized by law to provide.

Section 6.1: Timeliness Requirements

All providers will give appointments and covered services to BlueCross Medicare Advantage members within a reasonable amount of time.

<table>
<thead>
<tr>
<th>Category</th>
<th>Time Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care Appointment or Immunization</td>
<td>Within eight weeks of a member’s request</td>
</tr>
<tr>
<td>Routine Appointment</td>
<td>Within 14 days of a member’s request</td>
</tr>
<tr>
<td>Urgent Appointment</td>
<td>Within 48 hours of a member’s request</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediate</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>24 hours a day, seven days a week</td>
</tr>
</tbody>
</table>
Section 6.2: Telephone Responsiveness
During office hours, a physician or designee will assess the member according to his or her health condition.

- 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 for two minutes or less.

Section 7: 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.

Section 7.1: 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’s 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.
Chapter Four: Claims Process

Section 1: 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 you submit a claim to us but should have sent it to Original Medicare, we will return the claim to you for submission to the local carrier or fiscal intermediary.

Section 1.1: 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, we process claims for our Medicare Advantage members. Additional information is available from CMS on its website.

You 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. We cannot process claims with incorrect or missing alpha prefixes and member identification numbers. We will return (paper submission) or deny (electronic submission) claims you submit without all required information.

We 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, you must submit completely and accurately coded claims and assist us in correcting any identified errors or omissions.

Section 2: How to File Claims
BlueCross encourages providers to submit all claims within 12 months of 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.

Submit claims electronically to BlueCross using Medicare billing guidelines. We will pay all claims for Medicare Advantage plans. Payments will not come from a fiscal intermediary or Part B carrier.

Do not use a member’s Social Security Number for filing claims. For prompt payment, providers should transmit claims in the HIPAA 837 format using the appropriate payer code C63.

The mailing address for Medicare Advantage products is:
   Medicare Advantage
   P.O. Box 100191
   Columbia, SC 29202-3191
Section 3: How to File Claims for Supplemental Dental and Vision benefits

Avesis is an independent company that administers routine dental and routine vision benefits on behalf of BlueCross.

Use Avesis carrier (payer) identification code 86098 for dental claims. For routine vision claims, use Avesis carrier (payer) identification code 87098.

The mailing address for Avesis is:
Avesis Claims Center
Attn: [Dental or Vision]
P.O. Box 7777
Phoenix, AZ  85011

Section 4: BlueCard and Medicare Advantage

BlueCard is a national program that enables members of one Blue Plan to get healthcare service benefits while traveling or living in another Blue Plan’s service area. The program links participating health care providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan. Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution. Medicare Advantage is a separate program from BlueCard. Because you can see members of other Blue Plans who have Medicare Advantage coverage, this section addresses how to identify members and process these claims.

Section 4.1: Providing Services to other Blue Plans’ Medicare Advantage members

If you are a contracted Medicare Advantage provider with BlueCross, you must give members of other Medicare Advantage Blue plans the same access to care as you do for our beneficiaries. You can expect to receive the same contracted rates for such services.

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

If your practice is not accepting new Medicare Advantage patients, you do not have to provide care for out-of-area Medicare Advantage members. The same contractual arrangements apply to these out-of-area network-sharing members as your local Medicare Advantage members.
Section 4.2: Medicare Advantage PPO Network Sharing

A Medicare Advantage Preferred Provider Organization (PPO) plan allows members who enroll access to services provided outside the contracted network of providers. Required member cost sharing may be greater when covered services are received out of network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PPO members have in-network access to Blue MA PPO providers. Network sharing allows MA PPO members from other Blue Plans to get in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 34 states and one territory.

<table>
<thead>
<tr>
<th>Alabama</th>
<th>Arkansas</th>
<th>California</th>
<th>Colorado</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>Florida</td>
<td>Georgia</td>
<td>Hawaii</td>
</tr>
<tr>
<td>Idaho</td>
<td>Indiana</td>
<td>Kentucky</td>
<td>Maine</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Michigan</td>
<td>Missouri</td>
<td>Montana*</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Nevada</td>
<td>New Hampshire</td>
<td>New Jersey</td>
</tr>
<tr>
<td>New Mexico*</td>
<td>New York</td>
<td>Ohio</td>
<td>Oklahoma*</td>
</tr>
<tr>
<td>Oregon</td>
<td>Pennsylvania</td>
<td>Puerto Rico</td>
<td>South Carolina</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Texas</td>
<td>Utah</td>
<td>Virginia</td>
</tr>
<tr>
<td>Washington</td>
<td>Wisconsin</td>
<td>West Virginia</td>
<td></td>
</tr>
</tbody>
</table>

*participating effective January 1, 2014

BlueCross Medicare Advantage PPO network sharing does not change your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat. Benefits will be based on the Medicare-allowed amount for covered services and be paid under the member’s out-of-network benefits unless for urgent or emergency care. Once you submit the MA claim, BlueCross will send you the payment.

For questions about the Medicare Advantage PPO network-sharing program, contact Provider Education at provider.education@bcbssc.com.

Section 4.3: How to Identify Other Blue Plans Medicare Advantage Members

The “MA” in the suitcase on the member’s BlueCross identification card indicates coverage under the network-sharing program. Members should not show their Original Medicare identification card when receiving services.
Section 4.4: BlueCard Eligibility
Call the BlueCard Eligibility Line at 800-676-BLUE (2583) and provide the member’s three-digit alpha prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members by:
1. Logging in to My Insurance Manager
2. Entering the required data
3. Submitting your request

If you experience difficulty getting eligibility information, please record the alpha prefix and report it to provider.education@bcbssc.com.

Section 4.5: Member Cost Share under BlueCard
A MA PPO member cost-sharing level and co-payment is based on the member’s health plan. You can collect the copayment amounts from the member at the time of service. To determine the cost sharing and/or copayment amounts, you should call the Eligibility Line at 800-676-BLUE (2583).

You should not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, coinsurance and non-covered services). Under certain circumstances, when the member has been notified in advance that a service will not be covered, you can request payment from the member before services are rendered or billed to the member. The member should sign an Advance Beneficiary Notification (ABN) form before services are rendered in these situations.

Section 4.6: BlueCard Claims
You should submit the claim to BlueCross under your current billing practices. Providers in our Medicare Advantage network are required to file claims electronically to us unless they have an exemption from Medicare. To facilitate prompt payment when transmitting claims in the HIPAA 837 format you should use payer (carrier) code C63. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

If you are an in-network provider with BlueCross, benefits will be based on your contracted Medicare Advantage rate for providing covered services to Medicare Advantage members from any MA PPO Plan. Once you submit the MA claim, we will work with the other Plan to determine benefits and send you the payment.

When you provide covered services to other Blue Medicare Advantage out-of-area members, benefits will be based on the Medicare-allowed amount. Once you submit the MA claim, BlueCross will send you the payment. These services will be paid under the member’s out-of-network benefits, however, unless for urgent or emergency care.
Section 4.7: Provider Reimbursement
We reimburse you for covered services in accordance with your contracted Medicare Advantage rate with BlueCross. You cannot balance bill members for the difference in their charges and the allowance. You can bill members for any deductibles, coinsurance and/or copayments.

For information concerning the reimbursement amount, contact BlueCross via My Insurance Manager from our website or call 800-868-2510.

Section 5: Claim Status
You can submit claim status inquiries by visiting www.SouthCarolinaBlues.com and logging into My Insurance Manager. You can also access claim status through the VRU by calling 800-288-2227, ext. 43664.

Section 6: Claim Payment
If you do not receive payment for a claim, it is not necessary to resubmit the claim. This confuses members because they receive multiple Explanations of Benefits (EOBs).

You should check claim status by either calling Provider Services VRU at 800-868-2510, or in My Insurance Manager at www.SouthCarolinaBlues.com.

In some cases, a claim may pend because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, we will notify you in writing (via your remittance or a letter) requesting the additional information.

Section 7: Corrected Claims
If an adjustment for charges is required, resubmit a corrected claim with the correct charges. Please do your best to bill correctly the first time and limit the number of corrected claims that you file to us. Corrected claims require manual intervention and may decrease your claim adjudication times.

Section 8: 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.

Section 9: CMS-1500 Claim Form
The National Uniform Claim Committee (NUCC) has approved a new CMS-1500 health insurance claim form, version 02/12. This new version of the claim form became effective January 1, 2014. Dual use of the older CMS-1500, version 08/05 and the new claim form will be acceptable until March 31, 2014. Only the new CMS-1500 will be allowed after that date.
The CMS-1500 form is the standard paper claim form used by providers or suppliers to bill Medicare Fee-For-Service (FFS) contractors. You can only use this form if you have received an exception from the Administrative Simplification Compliance Act (ASCA). ASCA requires that claims be sent electronically to BlueCross Medicare Advantage unless a provider qualifies for an exception waiver.

Sample CMS-1500 Health Insurance Claim Form, version 02/12
If you qualify to submit paper claims, follow these instructions when completing your CMS-1500 claim forms:

<table>
<thead>
<tr>
<th>Item</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td><strong>Insured's ID Number:</strong>&lt;br&gt;Enter the patient's identification number, including the three-character alpha prefix.</td>
</tr>
<tr>
<td>2</td>
<td><strong>Patient's Name:</strong>&lt;br&gt;Enter the patient's last name, first name and middle initial, if any, as shown on the patient's Medicare Advantage identification card.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Patient's Birthdate:</strong>&lt;br&gt;Enter the patient's 8-digit birth date (MM/DD/YYYY) and sex.</td>
</tr>
<tr>
<td>4</td>
<td><strong>Insured's Name:</strong>&lt;br&gt;List the name of the policyholder here. When the policyholder and the patient are the same, enter the word &quot;Same.&quot; If Medicare is primary, leave blank.</td>
</tr>
<tr>
<td>5</td>
<td><strong>Patient's Address:</strong>&lt;br&gt;Enter the patient's mailing address and telephone number.</td>
</tr>
<tr>
<td>6</td>
<td><strong>Patient's Relationship to Insured:</strong>&lt;br&gt;Check the appropriate box to indicate the patient's relationship.</td>
</tr>
<tr>
<td>7</td>
<td><strong>Insured's Address:</strong>&lt;br&gt;Enter the policyholder's complete address and telephone number. When the address is the same as the patient's, enter the word &quot;Same.&quot;</td>
</tr>
<tr>
<td>8</td>
<td><strong>Patient Status:</strong>&lt;br&gt;Check the appropriate box for the patient's marital status and whether employed or a student.</td>
</tr>
<tr>
<td>9</td>
<td><strong>Other Insured's Name:</strong>&lt;br&gt;If applicable, enter the last name, first name and middle initial of the other insured enrollee.</td>
</tr>
<tr>
<td>9a</td>
<td><strong>Other Insured's Policy or Group Number:</strong>&lt;br&gt;Enter the policy and/or group number&lt;br&gt;<strong>Note:</strong> Complete Item 9d if you enter a policy and/or group number in Item 9a.</td>
</tr>
<tr>
<td>9b</td>
<td><strong>Other Insured's Date of Birth:</strong>&lt;br&gt;Enter the other insured's 8-digit birth date (MM/DD/YYYY) and sex.</td>
</tr>
<tr>
<td>9c</td>
<td><strong>Employer's Name or School Name:</strong>&lt;br&gt;Enter the employer's or school's name.</td>
</tr>
<tr>
<td>9d</td>
<td><strong>Insurance Plan Name or Program Name:</strong>&lt;br&gt;Enter the insurance plan name or program name.</td>
</tr>
<tr>
<td>10a-10c</td>
<td><strong>Is the Patient's Condition Related to:</strong>&lt;br&gt;Check &quot;Yes&quot; or &quot;No&quot; to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in this</td>
</tr>
<tr>
<td>Item</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td>10d</td>
<td><strong>Reserved for Local Use:</strong>&lt;br&gt;Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.</td>
</tr>
<tr>
<td>11</td>
<td><strong>Insured's Policy Group or FECA Number:</strong>&lt;br&gt;you must complete this item. We will reject it if it is blank.</td>
</tr>
<tr>
<td>11a</td>
<td><strong>Insured's Date of Birth:</strong>&lt;br&gt;Enter the insured's 8-digit birth date (MM/DD/YYYY) and sex if different from Item 3.</td>
</tr>
<tr>
<td>11b</td>
<td><strong>Employer's Name or School Name:</strong>&lt;br&gt;Enter the employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) retirement date preceded by the word &quot;Retired.&quot;</td>
</tr>
<tr>
<td>11c</td>
<td><strong>Insurance Plan Name or Program Name:</strong>&lt;br&gt;Enter the 9-digit Payer ID number for the primary insurer. This is required if there is insurance primary to Medicare that is indicated in Item 11.</td>
</tr>
<tr>
<td>11d</td>
<td><strong>Is There Another Health Benefit Plan?</strong>&lt;br&gt;Leave blank. Not required by Medicare.</td>
</tr>
<tr>
<td>12</td>
<td><strong>Patient's or Authorized Person's Signature:</strong>&lt;br&gt;The patient or authorized representative must sign and enter either a 6-digit date (MM/DD/YY), 8-digit date (MM/DD/YYYY) or an alphanumeric date (e.g., January 1, 2009) unless the signature is on file.</td>
</tr>
<tr>
<td>13</td>
<td><strong>Insured's or Authorized Person's Signature:</strong>&lt;br&gt;The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization.</td>
</tr>
<tr>
<td>14</td>
<td><strong>Date of Current:</strong>&lt;br&gt;Enter either an 8-digit (MM/DD/YYYY) or 6-digit (MM/DD/YY) date of current illness, injury or pregnancy.</td>
</tr>
<tr>
<td>15</td>
<td><strong>If the Patient Has Had Same or Similar Services/Illness, Give First Date:</strong>&lt;br&gt;Leave blank. Not required by Medicare.</td>
</tr>
<tr>
<td>16</td>
<td><strong>Dates Patient Unable to Work in Current Occupation:</strong>&lt;br&gt;If the patient is employed and is unable to work in his/her current occupation, enter an 8-digit (MM/DD/YYYY) or 6-digit (MM/DD/YY) date.</td>
</tr>
<tr>
<td>17</td>
<td><strong>Name of Referring Physician or Other Source:</strong>&lt;br&gt;Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.</td>
</tr>
<tr>
<td>17a</td>
<td><strong>ID Number of Referring Physician:</strong>&lt;br&gt;Leave blank.</td>
</tr>
</tbody>
</table>
| 17b  | **NPI Number of Referring Physician:**<br>Enter the NPI of the referring/ordering physician listed in Item 17.<br>*Note:* Field 17b is required when a service was ordered or referred by a
### Hospitalization Dates Related to Current Services:
Enter either an 8-digit (MM/DD/YYYY) or a 6-digit (MM/DD/YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.

### Reserved for Local Use:
Unless indicated, do not enter any other documentation in Item 19 of the CMS-1500 claim form.

### Outside Lab Charges:
Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation.
**Note:** This is a required field when billing for diagnostic tests subject to purchase price limitations.

### Diagnosis or Nature of Illness or Injury:
Enter the patient’s diagnosis/condition. Use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnosis codes.

For form version 02/12, it may be appropriate to use either ICD-9-CM or ICD-10-CM codes depending upon the dates of service.

The “ICD Indicator” identifies the ICD code set being reported. Enter the applicable ICD indicator according to these:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Code Set</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>ICD-9-CM diagnosis</td>
</tr>
<tr>
<td>0</td>
<td>ICD-10-CM diagnosis</td>
</tr>
</tbody>
</table>

### MEDICAID RESUBMISSION CODE:
Leave blank. Not required by Medicare.

### PRIOR AUTHORIZATION NUMBER:
Enter the prior authorization number for those procedures requiring prior approval.

### The six service lines in section 24 have been divided horizontally to accommodate submission of both the NPI and legacy identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.

At this time, the shaded area in 24a through 24h is not used by Medicare.

### Date(s) of Service:
Enter a 6-digit (MM/DD/YY) or 8-digit (MM/DD/YYYY) date for each procedure, service or supply. When “from” and “to” dates are shown for a series of identical services, enter the number of days or units in column 24G.

### Place of Service:
Enter the appropriate place of service code(s) from the list provided in IOM 100-04, Chapter 26, Section 10.5.

**Note:** When a service is rendered to a hospital inpatient, use the “inpatient hospital” code.
| 24C | **Type of Service:**  
Medicare providers are not required to complete this item. |
| 24D | **Procedures, Services or Supplies:**  
Enter the procedures, services or supplies using the CMS Health Care Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. |
| 24E | **Diagnosis Code:**  
Enter the diagnosis code reference number or letter as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. If a situation arises where two or more diagnoses are required for a procedure code (e.g., Pap smears), reference only one of the diagnoses in item 21. |
| 24F | **Charges:**  
Enter the charge for each listed service. |
| 24G | **Days or Units:**  
Enter the number of days or units. |
| 24H | **EPSDT Family Plan:**  
Leave blank. Not required by Medicare. |
| 24I | **Legacy Qualifier Rendering Provider:**  
Leave blank. |
| 24J | **NPI Rendering Provider:**  
Enter the rendering provider’s NPI number in the lower portion. |
| 25 | **Federal Tax ID Number:**  
Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number. |
| 26 | **Patient’s Account Number:**  
Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist you in patient identification. |
| 27 | **Accept Assignment:**  
Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits. |
| 28 | **Total Charges:**  
Enter total charges for the services (i.e., total of all charges in item 24f). |
| 29 | **Amount Paid:**  
Enter the total amount the patient paid on the covered services only.  
**Note:** This is not the amount the primary insurance paid. |
| 30 | **Balance Due:**  
Leave blank. Not required by Medicare. |
|   | **Signature of Physician or Supplier:**  
Enter the signature of provider of service or supplier, or his/her representative and the 6-digit date (MM/DD/YY), 8-digit date (MM/DD/YYYY) or alpha-numeric date (e.g., January 1, 2009) the form was signed. |
|---|---|
| 32 | **Name and Complete Address of Facility (Including ZIP Code) Where Services Were Rendered:**  
Enter the name, address and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, facility, physician's office or patient's home. |
| 32a | **Facility NPI Number**  
Enter the NPI of the service facility. |
| 32b | **Facility Qualifier and Legacy**  
Leave blank. |
| 33 | **Physician's Supplier's Billing Name, Address, ZIP Code and Phone Number:**  
Enter the provider of service/supplier's billing name, address, ZIP code and telephone number. |
| 33a | **Billing Provider NPI Number**  
Enter the NPI of the billing provider or group. |
| 33b | **Billing Provider Qualifier and Legacy Number**  
Leave blank. |
Section 10: Uniform Bill (UB-04) Claim Form

The Uniform Bill (UB-04) is the standardized form for institutional services. The National Uniform Billing Committee (NUBC) offers a UB-04 billing guide published by the American Hospital Association, called the National Uniform Billing Guide.

Sample UB-04 Claim Form
Section 10.1: Required Fields on the UB-04

This list identifies the required fields that providers must complete for claims to process accurately. 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 provides basic filing instructions providers need to submit services for payment.

- Field 1
  Enter the billing name, street address, city, state, ZIP code and telephone number of the billing provider submitting the claim. Note: This should be the facility address.

- Field 2
  Enter the name, street address, city, state and ZIP code where the provider submitting the claims intends to send payment. Note: This is required when information is different from the billing provider’s information in form locator 1.

- Field 3a — PATIENT CONTROL NUMBER
  Enter the patient’s unique alphanumeric control number assigned to the patient by the provider.

- Field 3B — MEDICAL RECORD NUMBER
  Enter the number assigned to the patient’s medical record by the provider.

- Field 4 — TYPE OF BILL
  Enter the appropriate code that indicates the specific type of bill, such as inpatient, outpatient, late charges, etc. For more information on Type of Bill, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

- Field 5 — FEDERAL TAX NUMBER
  Enter the service provider’s federal Tax Identification Number.

- Field 6 — STATEMENT COVERS PERIOD (From/Through)
  Enter the beginning and ending service dates of the period included on the bill using a six-digit date format (MMDDYY). For example: 010107.

- Field 7
  Reserved for assignment by the NUBC. Providers do not use this field.

- Field 8a — PATIENT IDENTIFIER
  Enter the patient’s identifier. Note: The patient identifier is situational and/or conditional, if different than what is in field locator 60 (Insured’s Unique Identifier).
• Field 8b — PATIENT NAME
Enter the patient’s last name, first name and middle initial.

• Field 9 — PATIENT ADDRESS
Enter the patient’s complete mailing address (fields 9a 9e), including street (9a), city (9b), state (9c), ZIP code (9d) and country code (9e), if applicable to the claim.

• Field 10 — BIRTHDATE
Enter the patient’s date of birth using an eight-digit date format (MMDDYYYY). For example: 01281970.

• Field 11 — SEX
Enter the patient’s gender using an F for female or M for male.

• Field 12 — ADMISSION DATE (MMDDYY)
Enter the patient’s admission date using a six-digit format (MMDDYY). Note: Required on all inpatient claims.

• Field 13 — ADMISSION HOUR
Enter the appropriate two-digit admission code referring to the hour during which the patient was admitted. Note: Required on all inpatient claims. For more information on Admission Hour, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

• Field 14 — ADMISSION TYPE
Enter the appropriate two-digit type of visit priority code for the admission/visit.

• Field 15 — ADMISSION SOURCE
Enter the appropriate admission or visit referral source code.

• Field 16 — DISCHARGE HOUR
Enter the appropriate two-digit discharge code referring to the hour during which the patient was discharged. Note: Required on all inpatient claims.

• Field 17 — PATIENT DISCHARGE STATUS
Enter the appropriate two-digit code indicating the patient’s discharge status. Note: Required on all inpatient, observation or emergency room care claims.

• Fields 18-28 — CONDITION CODES
Enter the appropriate two-digit condition code or codes if applicable to the patient’s condition.

• Field 29 — ACCIDENT STATE
Enter the appropriate two-digit state abbreviation where the auto accident occurred, if applicable to the claim.

- Field 30
  Reserved for assignment by the NUBC. Providers do not use this field.

- Fields 31-34 — OCCURRENCE CODE/DATE (MMDDYY)
  Enter the appropriate two-digit occurrence code and associated date using a six-digit format (MMDDYY), if there is an occurrence code appropriate to the patient's condition.

- Fields 35-36 — OCCURRENCE SPAN CODE/DATE (From/Through) (MMDDYY)
  Enter the appropriate two-digit occurrence span code and related from/through dates using a six-digit format (MMDDYY) that identifies an event that relates to the payment of the claim. These codes identify occurrences that happened over a span of time.

- Field 37
  Reserved for assignment by the NUBC. Providers do not use this field.

- Field 38 — RESPONSIBLE PARTY NAME/ADDRESS
  Enter the name, address, city, state and ZIP code of the party responsible for the bill.

- Fields 39-41 — VALUE CODES AND AMOUNTS
  Enter the appropriate two-digit value code and value if there is a value code and value appropriate for this claim.

- Field 42 — REVENUE CODE
  Enter the applicable Revenue Code for the services rendered. For more information on Revenue Codes, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

- Field 43 — REVENUE DESCRIPTION
  Enter the applicable Revenue Code description for the services rendered. For more information on Revenue Descriptions, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

- Field 44 — HCPCS/RATES/HIPPS CODE
  Enter the applicable HCPCS (CPT)/HIPPS rate code for the service line item if the claim was for ancillary outpatient services and accommodation rates. Also, report HCPCS modifiers when a modifier clarifies or improves the reporting accuracy.

- Field 45 — SERVICE DATE
  Enter the applicable six-digit format (MMDDYY) for the service line item if the claim was for outpatient services, SNF\PPS assessment date or needed to report the creation date for line 23. The 23rd line contains an incrementing page and total number of pages for
the claim on each page, creation date of the claim on each page and a claim total for covered and non-covered charges on the final claim page only indicated using Revenue Code 0001. For more information on Service Dates, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

- **Field 46 — SERVICE UNITS**
Enter the number of units provided for the service line item.

- **Field 47 — TOTAL CHARGES**
Enter the total charges using Revenue Code 0001. Total charges include both covered and non-covered services. For more information on Total Charges, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

- **Field 48 — NON-COVERED CHARGES**
Enter any non-covered charges as it pertains to related Revenue Code. For more information on Non-Covered Charges, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

- **Field 49**
Reserved for assignment by the NUBC. Providers do not use this field.

- **Field 50 — PAYER NAME**
Enter the health plan that the provider might expect payment for the claim.

- **Field 51 — HEALTH PLAN IDENTIFICATION NUMBER**
Enter the number used by the primary (51a) health plan to identify itself. Enter a secondary (51b) or tertiary (51c) health plan, if applicable.

- **Field 52 — RELEASE OF INFORMATION**
Enter a Y or N to indicate if the provider has a signed statement on file from the patient or patient's legal representative allowing the provider to release information to the carrier.

- **Field 53 — ASSIGNMENT OF BENEFITS**
Enter a Y, N or W to indicate if the provider has a signed statement on file from the patient or patient's legal representative assigning payment to the provider for the primary payer (53a). Enter a secondary (53b) or tertiary (53c) payer, if applicable.

- **Field 54 — PRIOR PAYMENTS**
Enter the amount of payment the provider has received (to date) by the health plan toward payment of the claim.

- **Field 55 — ESTIMATED AMOUNT DUE**
Enter the amount estimated by the provider to be due from the payer.
• Field 56 — NATIONAL PROVIDER IDENTIFIER (NPI)
Enter the billing provider's 10-digit NPI number.

• Field 57 — OTHER PROVIDER IDENTIFIER
Reserved for taxonomy code. Used for Medicaid claims.

• Field 58 — INSURED’S NAME
Enter the name of the individual (primary 58a) under whose name the insurance is carried. Enter the other insured's name when other payers are known to be involved (58b and 58c).

• Field 59 — PATIENT’S RELATIONSHIP TO INSURED
Enter the appropriate two-digit code (59a) to describe the patient's relationship to the insured. If applicable, enter the appropriate two-digit code to describe the patient's relationship to the insured when other payers are involved (59b and 59c).

• Field 60 — INSURED’S UNIQUE IDENTIFIER
Enter the insured's identification number (60a). If applicable, enter the other insured's identification number when other payers are known to be involved (60b and 60c).

• Field 61 — INSURED’S GROUP NAME
Enter insured's employer group name (61a). If applicable, enter other insured's employer group names when other payers are known to be involved (61b and 61c).

• Field 62 — INSURED’S GROUP NUMBER
Enter insured's employer group number (62a). If applicable, enter other insured's employer group numbers when other payers are known to be involved (62b and 62c).

• Field 63 — TREATMENT AUTHORIZATION CODES
Enter the pre-authorization for treatment code assigned by the primary payer (63a). If applicable, enter the pre-authorization for treatment code assigned by the secondary and tertiary payer (63b and 63c).

• Field 64 — DOCUMENT CONTROL NUMBER (DCN)
Enter if this is a void or replacement bill to a previously adjudicated claim (64a, 64c).

• Field 65 — EMPLOYER NAME
Enter when the employer of the insured if known to potentially be involved in paying claims. For more information on Employer Name, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

• Field 66 — DIAGNOSIS AND PROCEDURE CODE QUALIFIER
Enter the required value of nine or only for the special conditions enter a 0. Note: 0 is allowed if ICD-10 is named as an allowable code set under HIPAA. For more
• Field 67 — PRINCIPAL DIAGNOSIS
Enter the principal diagnosis code for the patient’s condition. For more information on POAs, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

• Fields 67a-q — ADDITIONAL DIAGNOSIS CODES
Enter additional diagnosis codes if more than one diagnosis code applies to claim.

• Field 68
Reserved for assignment by the NUBC. Providers do not use this field.

• Field 69 — ADMITTING DIAGNOSIS CODE
Required when a claim involves an inpatient admission.

• Field 70 — PATIENT’S REASON FOR VISIT
Enter the appropriate reason for visit code only for bill types 013X and 085X and 045X, 0516, 0526, or 0762 (observation room).

• Field 71 — PROSPECTIVE PAYMENT SYSTEM (PPS) CODE
Enter the DRG based on software for inpatient claims when required under contract grouper with a payer.

• Field 72 — EXTERNAL CAUSE OF INJURY (ECI) CODE
Enter the cause of injury code or codes when injury, poisoning or adverse effect is the cause for seeking medical care.

• Field 73
Reserved for assignment by the NUBC. Providers do not use this field.

• Field 74 — PRINCIPAL PROCEDURE CODE AND DATE (MMDDYY)
Enter the principal procedure code and date using a six-digit format (MMDDYY) if the patient has undergone an inpatient procedure. Note: Required on inpatient claims.

• Fields 74a-e — OTHER PROCEDURE CODES AND DATES (MMDDYY)
Enter the other procedure codes and dates using a six-digit format (MMDDYY) if the patient has undergone additional inpatient procedure. Note: Required on inpatient claims.

• Field 75
Reserved for assignment by the NUBC. Providers do not use this field.
• Field 76 — ATTENDING PROVIDER NAME AND IDENTIFIERS
Enter the attending provider's NPI number, taxonomy code (used for Medicaid claims), last name and first name. For more information on Attending Provider, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

• Field 77 — OPERATING PROVIDER NAME AND IDENTIFIERS
Enter the operating provider's NPI number, taxonomy code (used for Medicaid claims), last name and first name. For more information on Operating Provider, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

• Fields 78-79 — OTHER PROVIDER NAME AND IDENTIFIERS
Enter any other provider’s NPI number, taxonomy code (used for Medicaid claims), last name and first name. For more information on Other Provider, refer to the National Uniform Billing Committee’s Official UB-04 Data Specifications Manual.

• Fields 80 — REMARKS
Enter any information that the provider deems appropriate to share that is not supported elsewhere.

• Field 81CCa-d — CODE-CODE FIELD
Note: Reserved for taxonomy code. Used for Medicaid claims (preceded by B3 qualifier). Report additional codes related to a Form Locator (overflow) or to report externally maintained codes approved by the NUBC for inclusion in the institutional data set. For more information on requirements for Form Locator 81, refer to the National Uniform Billing Committee's Official UB-04 Data Specifications Manual.

Section 11: 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:

1. Billing/data entry errors
2. Noncompliance with coverage policy
3. 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, we will adjust or correct the claim.
Section 11.1: 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 when the status code 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 HCPCS code
- Missing or incorrect quantity

Section 11.2: Compliance Issues Resulting in Claim Denials
We may deny coverage or reject a claim for these reasons:

1. The patient is not eligible for Medicare Advantage benefits.
2. The provider is not qualified to furnish the Medicare services billed.
3. 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:

a. The service is not covered.
b. A limited benefit is exhausted.
c. Claim/services do not meet technical requirements for payment, e.g., non-compliance with Correct Coding Initiative (CCI) edits (including national and local requirements).

Section 12: 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 cannot bill beneficiaries for amounts Medicare denies due to unbundling.
Section 13: Provider 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. We may not pay for services furnished by excluded providers. In addition, we 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.

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 14: Balance Billing

Providers can collect only applicable copayments or coinsurance amounts from Medicare Advantage members and cannot otherwise charge or bill the members for covered services. BlueCross prohibits balance billing by network and deemed providers who provide covered services to Medicare Advantage members. You should collect copayments or coinsurance for covered services from the member at the time of service. If a provider (either deemed or not deemed) incorrectly collects more from a member than the designated copayment or coinsurance amount, you must refund the difference to the member.

Section 15: Advanced Beneficiary Notice (ABN)

Providers will issue an Advanced Beneficiary Notice of Noncoverage to Medicare members when it is expected that Medicare will deny the payment. It is not used for supplemental items or services provided under the Medicare Advantage program as outlined by Medicare. BlueCross will accept a valid ABN or written agreement on provider letterhead that confirms the agreement between you and the member.

You should notify the member at the time of service if Medicare statutorily excludes that service, and have the member complete a valid ABN or written agreement on provider letterhead. Collect payment up front from the member for statutorily excluded services or items, and then electronically file the claim with a GY modifier to the Medicare Advantage plan. We will conduct post-adjudication review to ensure the GY modifier is used appropriately and supported by a valid executed ABN or written agreement on provider letterhead. If an ABN or written agreement is deemed invalid and not acceptable the member is not liable for the charges. You must refund the payment to the member.
Section 16: Payment Methodology

In general, BlueCross pays claims per Medicare reimbursement methodology, less any applicable member cost-sharing amount, which you 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 network physicians submit. These reviews help us comply with CMS regulations and assist network physicians in achieving maximum reimbursement.

This table shows the payment process and payment responsibility.

<table>
<thead>
<tr>
<th>Role</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member</td>
<td>Pays the cost-share amount as stated in the contract up to the allowable fees the plan has established.</td>
</tr>
<tr>
<td>Provider</td>
<td>Submits to the local BlueCross and/or BlueShield Plan.</td>
</tr>
<tr>
<td></td>
<td>Bills members only the cost-share amount up to the allowable fees the plan has established. Providers can collect the cost share when they provide services.</td>
</tr>
<tr>
<td>BlueCross</td>
<td>Pays benefits directly to the provider.</td>
</tr>
</tbody>
</table>

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 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.

Section 17: Medical Review

Medicare contractors conduct the medical review 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 Determinations (NCDs), coverage provisions in interpretive manuals and local coverage determinations (LCDs) to comply with the Social Security Act.
Section 17.1: Medical Records

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.

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 you cannot alter initial descriptions of services provided, you can 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.

Any documentation that we may need for medical review of provider services may include, but are not limited to, medical records, laboratory and radiology reports, and a current list of prescribed medications and/or progress notes.

Section 17.2: Medical Records Requests

Providers should respond to our requests or from one of our business partners to review medical charts for a patient within five business days. The data we collect during this process not only supports the claims process, it helps us measure our performance, develop quality initiatives such as member outreach programs and enhance educational programs for providers and members.

Talk with your vendors and encourage them to cooperate with requests they may receive on your behalf. As a participating provider, your contract states you agree to permit BlueCross, or one of our business partners, to inspect, review and get copies of such records upon request at no charge. We appreciate you working with your vendors to ensure they understand this contractual arrangement to submit the requested records (on your behalf) without delay or request for payment.

Section 18: 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. Providers can visit CMS’ website for an NCD alphabetical index and to use the Medicare Coverage Databases.

Section 19: Local Coverage Determinations (LCDs)

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. 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. You can search for LCDs using the Medicare Coverage Databases found at www.cms.gov.
Chapter Five: Other Important Information

Section 1: Appeals
Please refer to your provider contract or terms and conditions for provider appeal rights. If you are dissatisfied with an initial claim determination, you can appeal a claim disposition by using the Medical Review Form on www.SouthCarolinaBlues.com. Be sure to include all supporting medical documentation and fax to the appropriate fax number on the bottom of the Medical Review Form.

Section 1.1: Levels of Appeals

• Level 1: Redetermination – Appealing the initial decision by BlueCross
  If you disagree with our decision of how we processed a claim, you can request a redetermination. The time limit for filing the appeal request is 120 days from the date of receipt of the initial determination. After reviewing, we will decide whether the initial decision should be affirmed, dismissed or reversed.

• Level 2: Reconsideration – Request for a review by an independent review organization
  If the claim has gone through the first level appeal process and you are still dissatisfied, you can then request an independent review organization review the claim. The time limit for filing the appeal request at this level is 180 days from the date of receipt of the redetermination. The organization will review the request and decide to affirm, dismiss or reverse the original decision.

• Level 3: Administrative Law Judge (ALJ) Hearing
  At this level of appeal request you can ask for an administrative law judge to consider the case and make a decision. The time limit for filing the appeal request is 60 days from the date of receipt of the reconsideration. The monetary threshold to be met is at least $130 that remains in controversy.

• Level 4: Departmental Appeals Board (DAB) Review
  At this level of appeal request the Departmental Appeals Board can review the case. The time limit for filing the appeal request is 60 days from the date of receipt of the ALJ hearing decision.

• Level 5: Federal Court Review
  If the provider disagrees with the decision the DAB made in appeal level 4, the federal court can review the case. The time limit for filing the appeal request is 60 days from date of receipt of the DAB decision or declination of review by the DAB. The dollar value of the contested benefit must be at least $1,350 in controversy.
Section 2: Medicare Advantage Contact Information

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